PUBLIC HEARING
JOINT LEGISLATIVE COMMITTEE
ON AGING

SEPTEMBER 12, 1980

PUBLIC HEARING

BY

STUDY COMMITTEE ON AGING

Columbia, September 12, 1980

Senator Hyman Rubin, Chairman

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A Public Hearing was held by the Joint Legislative Study Committee on Aging in the Senate Chamber of the State House, in Columbia, South Carolina, on Friday, September 12. The Hearing convened at 10:00 A.M.

Senator Hyman Rubin, Chairman of the Committee, called the Hearing to order, and in his opening remarks welcomed the guests on behalf of the Committee.

At the outset, he introduced those members of the Committee who were present as well as the staff personnel. Reverend Jack Meadors of Anderson, South Carolina, a gubernatorial appointee; Mrs. Gloria Trowell of Varnville, South Carolina, a gubernatorial appointee; Representative Parker Evatt of Columbia, South Carolina; Representative Pat Harris of Anderson, South Carolina. Mr. Harris is Vice Chairman of the Study Committee on Aging and also Chairman of the Committee on Mental Health and Mental Retardation. Mrs. Rose Mary Smith, Administrative Assistant to the Senate Medical Affairs Committee, who is very helpful in the joint efforts of these two Committees which are housed in the Medical Affairs Office suite. With everybody working together, said Senator Rubin, we can be efficient and hold down costs. Mrs. Keller Bungardner, the very able Administrative and Research Assistant of the Study Committee on Aging. Dr. Julian Parrish, another gubernatorial appointee, had just arrived and was introduced.

The Committee was established in 1969 as a so-called Study Committee and is now in its eleventh year. While it is designated as a Study Committee it is really a year-round working Committee, working on the concerns of the elderly and providing an opportunity for older people to call the office and get assistance and direction.

This Annual Public Hearing has been found to be extremely useful in providing guidance to the Committee in its programs and is, also, a very desirable forum for the older people and agencies involved. Today we have some 30 participants who will make their presentations. "We feel that we can be proud of our joint efforts. It certainly is 'joint'--the older people, the state agencies, which are so cooperative and help us at every turn, the Governor's Office, Comptroller General's Office, the Commission on Aging, DHEC, DSS, the Department of Mental Health, the Retirement System, represented by Mr. Purvis Collins, and many more. It is very gratifying to see how far we have come in terms of public interest and public

support. We continued last year to have a good legislative year. We achieved full funding for the Homestead Tax Exemption Program for $15,000 of market value, and the State is now spending some 12 million dollars a year in that Program. We had a package of bills to refine some aspects of the legislation, bringing up to date the life-time estate eligibility, providing for eligibility of older people who qualified and were serviced by a bank or trust; for pro-rating of eligibility where in some situations the property was owned by one or more who were eligible and one or more others who were not. We pursued the Long Term Community Care Project, a pilot project in Cherokee, Spartanburg and Union Counties. The General Assembly has been very generous in fully supporting this pilot project which is designed to screen people who need medical assistance with the object of keeping them out of nursing homes through home assistance and home care. This project will continue into 1982; it has already demonstrated; by working well, that this is the way of the future, and we hope in time that its success will speak for a statewide program so that people can get the help they need and the dignity and the privacy in the convenience of their homes rather than sending them to a nursing home or neglecting them."

He continued to state that a lot of progress has been made. The Hearing today will bring proposals and requests which will require a lot of funding. However, this is a tight year, and we try to be realistic at all times. As members of the General Assembly, we must relate to the realities of the situation and generate the confidence of our colleagues and operate in an objective effective, but nonpolitical manner. "We have endeavored over the years to engender the recognition of the worth and merit of older people, their continuing capacities and the opportunities for continued self-fulfillment." One example Senator Rubin cited here, was the bill which provided that persons over 60 could attend State institutions of higher learning without paying tuition on a space available basis.

In closing, Senator Rubin said that in a sense this Hearing and our activities are a fellowship of all of us with mutual concerns and recognition of the lifelong process of mutual dependence.

The first speaker was called to make a presentation.

Ms. Elizabeth Jack
District Director of Nursing
Health Screening and Surveillance
to the Elderly
P. O. Box 4217 Station B
Spartanburg, South Carolina

Ms. Jack is an employee of the Department of Health and Environmental Control and is the District Director of Nursing for Appalachia III Public Health District. Her statement addressed the need for prevention, promotion and maintenance of health for the elderly. The same type of services which are offered to mothers and children, must be made available for senior citizens.

She urged support of DHEC's additional budget request for FY 1982 for the Early Disease Detection and Control Services, which is included in the Agency's fifth priority.

After reading her prepared statement which is on the following pages, Mr. Pat Harris asked if they were providing home health care services in their program.

Ms. Jack told him that they have had home health care services for a long time in Appalachia III. They started these services in the early 1950's, and she thinks that they were the first ones in the State to provide these services.

Mr. Harris said that this proves to be very cost effective in preventing institutionalization. He said that he is watching this program very closely and is very much impressed with their services in District III. He hopes to be able to get the Program into District I.

Ms. Jack added that out of the total Medicare dollars 1/10 percent is spent for home health care, which shows where the remaining millions of dollars go to.

Senator Rubin expressed his appreciation to Ms. Jack for directing the Committee's attention to some very important problems.

At this point, Senator Rubin introduced two more Committee Members who had just joined the Hearing: Senator Bill Doar, Georgetown, and Senator Peden McLeod from Colleton. He also recognized Ms. Lorraine Callison, who is working as a page for the Committee and very helpful to the office.

My name is Elizabeth Jack. I am District Director of Nursing for Appalachia III Public Health District. Like the rest of the state and nation there has been a dramatic shift in the age structure of our society. There are increasing numbers of older persons primarily because of the declining birth rate and the increased life expectancy. During the past ten years in Spartanburg County alone the number of persons age 60 and older has increased by 2.5% or in actual numbers an increase of over 10,000. This increase in number of persons living on a limited or fixed income, coupled with the spiraling inflation has created a greater demand for traditional public health services such as prevention, promotion and maintenance of health. With limited purchasing power the elderly are forced to spend their health care dollars on curative or crises medicine. HCFA, our great National Health Care Financing Administration, should more appropriately be called SCFA or Sick Care Financing because it will only pay for treatment of an illness -- not prevention, promotion or maintenance of health.

You and I know this is a very expensive modal --

At a recent conference on Aging in Spartanburg, the elderly participants identified their greatest health care need as not being able to receive accessible, appropriate and timely health care. They neither had the up-front money to pay for physician care, nor transportation to get to care and even if they could they were not able to afford the necessary medications or treatments. One of their requests was -- that the Health Department conduct clinics appropriate to their needs similiar to those offered to women of child bearing age and children.

In an attempt to respond to a locally expressed unmet need, Appalachia III Health District initiated a Well Oldster Clinic at a congregate dining site. We provide health screening, referral, monitoring, counseling, and education services. The referrals from this clinic have resulted in the early detection of cancer, hypertension, diabetes and other significant diagnoses and our counseling, monitoring

and health education has hopefully prevented catastrophic events such as strokes from occurring.

Good news spreads fast. In almost every community in our district there is an organized group of senior citizens clamoring for the same services that are now being offered at our one Well Oldster Clinic. We are currently planning to expand to at least four more communities by January 1981. However, the first essential element for providing these services is manpower.

In keeping with our mission -- prevention, promotion and maintenance of health, we must offer appropriate, accessible, equitable -- this is the same type of services as we offer mothers and children -- to the elderly who have been our most productive responsible citizens. All of us are aware that the most articulate among the elderly emphasize they have been tax payers and should not be discriminated against in the availability of services.

We, therefore, request your support of DHEC's additional budgetary request for FY 82 for the Early Disease Detection and Control Services. This is included in the agency's fifth priority.

We must pay more attention to the prevention of disease and disability. We cannot afford to do therwise.

John Zuidema, Project Executive
Health Impaired Elderly Project
Community Care, Inc.
1601 Belleview St.
Columbia, SC 29204

Mr. Zuidema spoke on a project which he is operating here in Richland-Lexington Counties under a million dollar grant from the Robert Wood Johnson Foundation of Princeton, New Jersey. It was found out that there is no comprehensive system aimed at keeping people out of nursing homes. There are many programs that prevent unnecessary nursing home placement, but these programs are fragmented. We may have six or seven different agencies working with one elderly individual. Mr. Zuidema stressed the importance of developing an efficient system. Part of the blame goes to the way Medicare and Medicaid funds are earmarked for certain services—there is a lack of flexibility in the distribution of these funds.

The project administered by Community Care, Inc.,is called the Health Impaired Elderly Project which will assess health impaired elderly individuals in cooperation with local agencies and institutions to coordinate services. There are 16 agencies in the two counties—Richland and Lexington—where the Project is being conducted that have agreed to cooperate with Community Care.

The Foundation has allocated funds for up to five years. There are eight projects nationally funded by this Foundation and Community Care is one of the eight. Mr. Zuidema was proud to say that they are the only ones that have already assessed approximately 85 individuals 65 years and over who have significant health impairments. Some interesting statistics that they have found out in terms of the national statistics were that one-third of the U. S. health dollar is spent on the elderly. In the age group of 65 to 75, 10 percent of the elderly have significant health impairments which makes it difficult for them to live without support. In the age group over 75, the percentage of health impaired elderly goes to 25.

The primary goal of this Robert Wood Johnson grant is to maximize the quality of life and the level of indepence for the health impaired elderly.

The first objective of the Project was to identify the needs of the elderly through a comprehensive assessment instrument. This meant going into the home of everyone who had been referred to them, talking to the individuals and getting information as to their health needs, social needs, who may be available as a support person, such as relative, friend or neighbor. After assessment, a plan of care is drawn up, and then the available servies are linked to meet the needs of the individuals. For example, if home health care is necessary, they find a home health person; if homemaker services are needed, they contact DSS to request same. "We do not get into the business of providing services ourselves, we just function as a central agency for coordination of services," said Mr. Zuidema.

In closing he made a recommendation to the Committee to find some way of providing some incentive to county governments--perhaps a matching ratio from State dollars to County dollars--to begin delivering some essential services that are badly needed by the elderly, such as home-delivered meals. He said that in Lexington County they went from $15,000 a year out of their county appropriation for the elderly to $200,000.

"We have gotten into the trap of saying that if the Federal dollar is not available, we can't do it." He thinks that there can be some programs that we can afford to fund in South Carolina for our elderly.

Dr. Parrish wanted to know if any funds are available through this same agency for other reasons for the State.

Mr. Zuidema told him no, there were only eight grants and nor more funds are available for this endeavor.

Senator Rubin wondered if the appropriation in Lexington County which jumped so dramatically was not the one to fund their new Council on Aging, which separated from the Richland-Lexington Counties Councils on Aging.

Mr. Zuidema replied that this was additional money.

Senator Rubin remarked that the matter of coordination is very essential. He thanked Mr. Zuidema for his presentation. (Written statement is on the following pages).

NARRATIVE REPORT

Relative to accomplishments during the first six months of the Care Coordination for the Health Impaired Elderly Project.

Submitted to:

The Robert Wood Johnson Foundation

by

Community Care, Inc.

August 30, 1980

PROJECT NARRATIVE

Introduction

This demonstration project is funded by a grant to the South Carolina Commission on Aging from the Robert Wood Johnson Foundation of Princeton, New Jersey. It is administered by Community Care, Inc. under a contractual agreement with the Central Midlands Area Agency on Aging. A central coordinating unit has been developed in cooperation with local agencies and institutions to coordinate services for health impaired elderly persons.

PROJECT GOAL

To maximize the quality of life and independence for health impaired individuals sixty-five and over in Richland and Lexington Counties.

PROJECT OBJECTIVES

1. To identify and conduct a comprehensive assessment of the elderly who are unable to function independently so as to develop a plan for their care which increases access to and improves coordination of available services.

2. To provide support for persons who voluntarily provide assistance to the impaired elderly.

CRITERIA FOR REFERRAL

The Health Impaired Elderly Project will assess individuals without regard to income:

—who routinely need assistance with daily living activities due to long-term health impairments
--who are sixty-five and over
--who reside in Richland or Lexington County

Based on the assessment results, a plan of care will be developed and implemented in cooperation with the appropriate community agencies.

The following specific objectives were established for the first year of the Project:

1. To establish programatic and financial relationships with the State Commission on Aging and the Central Midlands Regional Planning Council.

2. To develop interagency cooperation and community support through the organization of a Community Advisory Council, a Policy Manager's Panel and a Services Panel.

3. To employ exceptionally well qualified staff to implement project objectives.

4. To assess and develop a plan of care for disabled elderly in Richland and Lexington Counties in the following sequence:

   a. Select a standardized client assessment instrument.

   b. Develop a detailed and current services inventory.

   c. Utilize the assessment instrument beginning June 30, 1980 with 200 clients referred by cooperating agencies and the community.

   d. Develop in cooperation with participating agencies, plans of care and service linkages for these persons.

   e. Obtain feedback from participating agencies and clients as to the effectiveness of these assessments and plans of care.

   f. Revise the assessment process, plan of care, and linkage procedures based upon the experience with the initial 200 clients.

5. To identify and facilitate existing and potential natural and community supports.

6. Develop a plan of action for year two based on the experiences of the previous year.

ACCOMPLISHMENT OF OBJECTIVES

During the First Six Months of Year One

The first objective has been achieved in that an agreement has been reached, whereby the South Carolna Commission on Aging will assume the status of Grantee effective August 1, 1980. The Commission has agreed to delegate the responsibility for the Project to the Area Agency on Aging which is a component of the Central Midlands Regional Planning Council. This Council has contracted with Community Care, Inc., to administer the Care Coordination Project.

The Area Agency on Aging will include the Project in its Annual Plan of Action and will encourage agencies funded through the Area Agency to cooperate fully with Project Staff.

In order to facilitate cooperation and coordination, the Project Executive will meet monthly with the Area Agency Staff and representatives of all the aging programs which are a part of the Area Agency on Aging network. In addition, quarterly meetings are being held which include the Director of the Central Midlands Regional Planning Council, the Director of the Area Agency on Aging, the Director of the South Carolina Commission on Aging, the Executive Coordinator of Community Care, and the Project Executive. These quarterly meetings are for review of progress and for the resolution of any problems which may have arisen.

The second objective has been partially achieved in that both the Policy Manager's Panel and the Services Panel have been organized and are meeting on a monthly basis with good attendance. The Services Panel deals with client referral and coordination issues while the Policy Manager's Panel deals with planning on an inter-agency level.

A delay in organizing the Community Advisory Council was experienced when the first choice of Chairperson was not available. However, a Chairperson has been found and the Council will hold its first meeting in September. At this meeting, the members will be oriented to the Project and given a preview of the Draft Action Plan for Year Two.

Objective three has been achieved in that the Project Executive was employed on March 1, 1980; the Administrative Assistant on April 7, 1980; and two Senior Care Coordinators reported for work in mid May. One Senior Care Coordinator has a Masters of Social Work degree with several years of experience with the aging in nursing homes. The other Senior Care Coordinator holds a Masters degree in Nursing and a Graduate Certificate in Gerontology. In addition, she has clinical experience as a senior nurse in a veteran's hospital nursing home care unit.

Three Associate Care Coordinators were employed as of July first. Two of these individuals had prior experience with the aging and another had experience in a mental health facility.

A Medical Consultant for the Project has been obtained. He is the Chairman of the Department of Family Medicine at the University of South Carolinas School of Medicine. Weekly meetings between the Medical Consultant, the Senior Care Coordinators and the Project Executive are being held.

The employment of a Data Manager has been postponed until the time when such services are needed.

Objective four has six sub-parts. An assessment instrument has been developed which has its base in the instruments developed by the Philadelphia Geriatric Institute under contract with the Pennsylvania Aging Program. This instrument is comprehensive in nature and includes a rating scale and information on the availability of social supports. A copy of this assessment is included in the appendix of this report.

A services inventory has been developed which is being revised as services expand or are curtailed. The Project Staff has drawn on the local United Way Directory of Services and on information provided by cooperating agencies in the development of the services inventory.

It is planned to assess two hundred clients as of January 31, 1981. During the first two months of service delivery (June and July) about forty clients were processed. This was a time when on-the-job training was being provided to the Associate Care Coordinators by the Senior Care Coordinators. The number of clients being assessed has increased each week and it is expected that the goal of two hundred by the end of year one will be reached.

Plans of care have been developed for the forty clients assessed in June and July. Most essential services are in short supply but cooperating agencies have been able to respond to the Project's request that clients be provided with Home Health Care, Home Delivered Meals, and Homemaker services. In several cases, church organizations have been able to assist clients to purchase drugs or pay utility bills.

It is too early in the Care Coordination process to seek formal feedback from cooperating agencies as to the effectiveness of the Projects coordination efforts. A feedback procedure is to be implemented during the Fall of 1980 in conjunction with the two hundred initial clients to receive care coordination by Project Staff.

Revisions in the manner in which the Project conducts its activities will occur early in the second year of the Project.

In regard to the fifth objective which deals with the natural support system, the Senior Care Coordinator (Social Worker) has been assigned the responsibility of leading the staff in relating to the relatives, friends, and church organizations which contribute to the care of health impaired individuals. The Project Executive is assisting in this activity. He has helped in the assessment of older members of a large downtown church to determine unmet needs. He is also working with a retired persons civic club to identify those persons who are natural caregivers for disabled older persons.

The last objective has to do with the Action Plan for Year Two. A timetable for the formulation of this Plan has been written and agreed to by the Staff including the Executive Coordinator of Community Care.

The Project Staff has been involved with the Harvard Evaluation Team in discussing methods and resources for base line evaluation and anticipates a second visit in September of 1980. Ken Johnson, M.D., the Project Officer, has been to Columbia to consult with Project Staff and to help orient members of the Policy Manager's Panel and Services Panel.

In summary, the first six months of the Project saw the hiring of staff, the equipping of offices, and the organization of the cooperating agency representatives into a Policy Manager's and a Services Panel. The process of Care Coordination was begun for clients referred by cooperating agencies. A re-channeling of Grant funds was accomplished without any negative impact on previous accomplishments.

Reverend Marvin Lare
Executive Coordinator
Community Care, Inc.
1101 Belleview St.
Columbia, SC 29201

The primary problem faced by chronically impaired persons is the question of who will take on the long-term care that these persons require. The burden usually falls on family members or close friends. Reverend Lare focused his comments on this rather newly emerging category called "caregivers." There is rarely any outside help available to relieve caregivers.

Community Care did a study on this group in our area and prepared data to develop solutions for caregivers. The agency interviewed 160 caregivers in the Columbia area. An additional study was made by four graduate students in the School of Social Work; they interviewed an additional 60 persons. In the last two years Community Care has accumulated more data on caregivers than any community in the nation. This is identifying a new client group. Reverend Lare made the following suggestions to the Committee:

1. Further study is needed in this area even though research has been extensive.
2. Find ways to lessen the financial burden for the families—the financial burden is a reoccurring issue for the families.
   . Florida and Maryland are granting tax advantages to families who are caregivers.
3. Assist caregivers so they can get respite.
4. Establish mutual support groups among caregivers.
5. No information is available for caregivers—need for preparation exists.

Reverend Lare mentioned that Community Care is issuing a newsletter to caregivers and said that they found in terms of service one of the best points is intervention at the time when a person anticipates a deterioration of a member in the family.

Two years ago, a Title XX contract was given to Community Care and to an agency in Charleston for the first time to provide voluntary companionship services for impaired adults. This use of volunteers in this capacity was a groundbreaking effort as most Title XX projects are to be used to pay for professional services rather than for the support of volunteer activities.

There were no questions asked by the Committee members. Senator Rubin thanked Reverend Lare for his valuable suggestions and congratulated him on receiving the grant from the Robert Wood Johnson Foundation.

(Written statement follows).

On file in the Committee are the following attachments: 1) Abstract on caregivers, 2) a paper on Caregivers of the Chronically Impaired, and 3) a Progress Report on the Fellowship of Caregivers Project of March 1980.

Testimony of Marvin I. Lare
before
Legislative Committee on Aging
September 12, 1980

Thank you. Senator Rubin, the Committee, staff, and friends, I will provide a transcript of my remarks which I am sharing informally and also a summary of some of the reports which I will refer to this morning.

The specific area I would like to focus my comments on is a rather new and emerging category which we have chosen to call "caregivers". It is defined in one of the studies I will refer to.

> . . . a primary problem faced by the chronically impaired and their families and friends is the burden of long term care. Who will provide this care? A recent Brandeis University study found that the family elected to provide long term care in 70% of the cases studied. This corroborates other professional literature and reports of Congressional hearings which indicate that in spite of the belief that family life has changed drastically, families do respond in time of need. The crucial role played by families in providing long term care is one of the major factors in preventing institutionalization of chronically ill, functionally impaired persons. These families and friends, called caregivers, who elect to provide long term, ongoing care for a chronically disabled, functionally impaired person, encounter unusual burdens and tremendous responsibilities with little or no outside support. They perform a crucial service to society and fill a vital role as caregivers to a large and growing population of chronically impaired persons, yet their needs have been virtually ignored by society.

Consistent with the concern expressed very succinctly in this paragraph, Community Care two years ago initiated a proposal to the Presiding Bishop's Fund for World Relief for a study of caregivers in our area, to gather data to be able to begin to form a data base upon which solutions might be developed to assist these caregivers. One of our presumptions in that study funded by the Episcopal Church was that a "Fellowship of Caregivers", a self-help support group, among these persons might be an excellent way of assisting them in carrying burdens of being a caregiver.

In order to gather data on this matter, we did structured interviews with 160 caregivers in the Greater Columbia Area. In an additional study, coordinated with our efforts and rising out of them, four graduate students at the School of Social Work also interviewed an additional 60 persons. Let me give you some idea of the cross section which was achieved in these 220 interviews of caregivers. Approximately 40 were directly referred through the Veteran's Administration Hospital. The great proportion of the balance that Community Care studied, around 120, were referred to us by the pastors and staff of churches in our community. We found that as we asked community service agencies to refer persons of this type it was a rather difficult and cumbersome procedure to receive referrals because of questions of confidentiality, etc., whereas the informal

systems in our community churches were far better able to refer and also gave us a welcome entry point when we could say that "your pastor suggested we might call you to discuss with you the responsibility you are carrying out as a caregiver". In this sample that Community Care studied, we identified that we were missing to a large extent minority and low income persons, and so the study carried out by the graduate students from the School of Social Work was planned to fill this gap in our studies by identifying unique characteristics and concentrating primarily on minority and low income persons in our community.

In essence, we have been able in the last two years to accumulate as much or more data on the subject as any other community in our nation. We believe this is an area which certainly needs to be developed with the encouragement and support of our community and state.

In essence we are identifying a new client group -- a client group or constituency which has not been seen or recognized as such in the past. While caregivers have been with us forever, nevertheless it is something that has been rather taken for granted. Yet as I pointed out, these persons cared for 70% of the long term impaired population. They have a tremendous impact upon the cost to society and the cost in human values when institutional alternatives rather than family solutions are selected in these situations.

Therefore, without going into great detail as far as the findings, let me just suggest a few matters for the Committee to explore further, and provide some recommendations and specific data for you on this subject.

First of all, while the research that has been done has been extensive and very helpful, there is an ongoing need for further development information in this area. Explorations ought to be made as far as how further studies can be funded and supported in this area since it has such a dramatic effect on the elderly.

Second, a re-occurring issue for families of persons who operate as caregivers is the financial burden which they bear. I would suggest that the Committee explore the ways in which the burdens of those caregivers may be able to be lightened in terms of financial responsibilities. Pilot projects in such activities are being carried out in the State of Florida and I believe in the State of Maryland in the form of tax advantages for persons who qualify as caregivers. Rather than pay out direct subsidies to caregivers, such a route might be more attractive, easier to accomplish, and a reasonable approach for reducing the financial burden of those who are sparing our society the high cost of institutionalization of these persons.

Third, I would recommend for consideration that the existing service systems within the state reorient their perspective to take into account this new client group of caregivers and assist these persons.

(A.) Among the things we have found in interviewing these care-

givers at the top of the list of their needs is respite -- a chance to be relieved from their burdens for a short period of time. These persons as you would recognize are twenty-four hours a day, seven days a week, three hundred sixty-five days a year caregivers. While within their own families some occasions for respite might be possible, we find that in the vast number of cases there is very little opportunity for these persons to get any relief from this ongoing responsibility. Therefore, along the way they either physically or emotionally break under the responsibility and are unable to continue. Some form of respite, relief would serve both the interests of the impaired person as well as the caregiver in these situations.

(B.) As I suggested initially, we explored extensively the possibilities of mutual support groups among caregivers. The primary hindrance to that was the inability to get away to get together. The meetings we have had of caregivers were extremely rich in the amount of sharing and the information and the emotional support. The identification of caregivers with one another was great saying, "Yes. I understand what you are doing", or "Have you tried this", or "What about that?" The cadre and the natural fellowship among these persons, I think, exists quite clearly, but it needs to be supported.

(C.) Another area in which our service institutions may be able to be of more help and assistance is simply in the area of information. We found that by and large caregivers enter upon their responsibilities with very little if any preparation by the physician, by community services, by any of the resources of our community. Just access to reliable information relevant to their needs is urgently needed.

One attempt of ours to do this is a newsletter entitled, "Caring", which we are publishing noew for the caregivers we have interviewed. We are able, even with the conclusion of the grant from the Episcopal Church, to continue this fund under the program which Mr. Zuidema just presented to you a few moments ago as one of the functions of the Health Impaired Elderly Project. This kind of vehicle could help to serve these caregivers in each community.

(D.) One further insight we found from our studies and those from similar efforts in other communities. We found that one of the best points of intervention with caregivers is very early on -- even before they fully enter the responsibility of caregiving. That is, when a person anticipates that "mother's condition is deteriorating to the extent that I am going to have to do something about it" or that "my husband has had a stroke and I'm going to become a caregiver". That is when persons are most ready and able to accept and learn and benefit. This is the point at which the services of our community ought to

Finally, let me mention a program which Community Care is carrying out under a contract with Title XX which we think has potential for caregivers and particularly in providing respite. If not in your legislative capacity, perhaps in your advisory capacity on Title XX priorities you may be able to assist.

Two years ago a Title XX contract was given to Community Care to provide voluntary companionship services for impaired adults. This use of volunteers to provide units of service in a Title XX contract was a ground breaking step. Title XX projects have been to pay for professional services rather than for the support of volunteer activities. We have found this pilot project to provide many learnings. While the focus of this companionship program has been to this point upon isolated elderly persons, we hopefully are going to redirect its focus to be more specifically towards imapired persons who are in a caregiver situation. Volunteers could be trained, and placed to help assist in respite care. As we further explore this area, we would hope that it will provide a model for others.

Thank you very much. I will be glad to respond to any questions you may have.

jcp

Dr. Hal French
Department of Religious Studies
University of South Carolina
Columbia, South Carolina

At this point, Senator Rubin informed the guests that Dr. Hal French had asked to make a few comments on the Natural Death Act. He was granted five minutes to speak on this subject.

Dr. French quoted a prayer from the Episcopal Book of Common Prayers:

"From terrors by night
and terrors by day,
perils by land,
and perils by sea,
and from sudden death,
Good Lord, deliver us".

He said that he is of the conviction that if this were subject to revision today the last line would be modified to say "....and from lingering death, Good Lord, deliver us."

In teaching subjects related to aging and one particular course in death and dying, over the last few years, it has been Dr. French's strong opinion that his students feel that they want to have control—as much as they can—over the circumstances of their life and their dying. Early on in the class, Dr. French has questioned his students about their fears relating to death. Overwhelmingly many will suggest that severe lingering illness and medical care which has done so much to enhance our lives has at this point given us a kind of dilemma—and a spectre of fear of so many persons that they won't be in control of these circumstances.

The Living Will, said Dr. French, is a consideration that we have looked at for several years in class, and last spring Keller Bumgardner presented a list of legislative priorities; and one of them that the students were particularly interested in was the support that the Committee has given to the Natural Death Act which has passed the Senate on two occasions and hopefully may have support in both legislative chambers this year.

Dr. French said that he has seen support for the Natural Death

Act reflected in his students. They have been excited about the possibilities of this and as other states have passed bills, Dr. French would like to see South Carolina enlist itself on the side of persons who really want to have control of this very important part of their lives. The bill was proposed in both Senate and House chambers. Dr. French suggested that now the Living Will would be given legal legs so that attention would be given to people's wishes in this regard in advance of possible circumstances that might deprive them of the ability to make such decisions at that time.

Dr. French said that among his students—as far as he can tell from reading test papers and speaking with them as well as other community and church groups on the subject—that there is near-unanimous support of the Natural Death Act. Dr. French expressed his hope that the Committee will give favorable support of this legislation as they have in the past.

Senator Rubin expressed his appreciation to Dr. French and told him that the Senate had faught very hard for passage of this legislation. There was as much support throughout the State as you could possibly get behind legislation—the State Methodists, Baptists, Medical Association, Senior Citizens Organizations, which are represented here today—but it got bogged down on the House side. This raises the question whether South Carolina is ready for it and how much time you can give by fighting something that can be killed by a determined—let's say—minority. No disparagement, rather Senator Rubin is impressed by their clout. He thought it was very desirable legislation and in keeping with the time and worldwide concern. Certainly the education that emanated from it did some good.

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As Director of the Seek-A-Senior Employment Referral Program, Mrs. Olafson finds that America is wasting our most valuable resource, the older worker. In early 1978, there were over 4 million older persons needing money and/or activity who wanted to work but were unemployed.

The Work in America Institute, a private nonprofit organization, proposes that employers design a variety of jobs and work arrangements for older people, such as part-time positions, job sharing and flexible time schedules. Employees staying on past 65 should not be expected to accept less benefits as their younger fellow-workers.

A study by the U. S. Labor Department Office of Research and Development cites evidence that discrimination against older worker continues. And this after passage of the Age Discrimination in Employment Act ten years ago!

A survey by Social Security states that 55 percent of men who stopped work between the age of 62 and 65 said they would have worked longer if they could.

The Seek-A-Senior Employment Referral Program has counseled 1,490 people over 50 and placed 488 of those in full or part-time employment.

Mrs. Olafson expressed her appreciation for the support she has received from the Committee and various agencies which was instrumental in securing funding for the Seek-A-Senior Program for twelve months by a Department of Labor grant, administered through the Office of the Governor, CETA Divsion. (Complete text of statement on the following pages).

Senator Rubin asked if Mrs. Olafson has ever had conferences with the Chamber of Commerce, because the educational process can emanate from them if they wish to cooperate.

Mrs. Olafson replied that she has talked to them and that she has had full cooperation from the Governor's Office, Department of Legal Services to the Employment Security Commission.

RICHLAND-LEXINGTON COUNCIL ON AGING
Mrs. Mary F. Clay
President
Fletcher Spigner
Executive Director

RLCOA
1800 Main Street - Suite 3-C
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September 12, 1980

REPORT TO LEGISLATIVE STUDY COMMITTEE ON AGING

PREPARED BY (MRS.) RANDI OLAFSON, DIRECTOR

SPECIAL PROGRAMS & SERVICES AND EMPLOYMENT REFERRAL

RICHLAND-LEXINGTON COUNCIL ON AGING

Senator Rubin, honorable committee members, and friends of older Americans: Last year at this time I was the new kid on the block, having worked in the aging network for two months. I was nervous and felt just a little presumptuous. How did I dare testify before this learned committee concerning the needs of older citizens after just learning there was such a thing as a Council on Aging just two months before? This year I'm still nervous but more confident in my knowledge in experiencing a second career.

When people ask me what I do, I conveniently say, "I work with the elderly". But I don't like the sound of it. It makes me sound noble and sacrificing and breast-beating and reeks of false humility. It always elicits the response, "My, that's wonderful. It must be terribly rewarding." It makes me feel like I'm promoting the "cause of the month" and will jump on a new bandwagon next month.

Yes, I find it rewarding - not terribly rewarding, but selfishly rewarding. I have learned warmth, understanding, patience, adjustment, and the list is endless. I have learned that the needs, problems, desires and hopes for the future of the older person are really no different than mine. They are not unique to them, sometimes more intense, but not unique.

When I applied for the position of the Director of the Seek-A-Senior Employment Referral Program last year, I was very anxious. I had not been on a job interview in ten years. At 34 years old, with a 13 year old Bachelor's Degree,

I felt inadequate to compete with everyone else, whom, I was sure, held Masters Degree or better, and were much younger and more confident than I. I was "going for" a job for which I'd had no training. A second career? At my age?

I quickly discovered as I counseled older workers, that their cry was exactly the same as mine had been. When you're fresh out of college, out to conquer the world, you're told "you don't have any experience". Several years later, proud of your accomplishments in the labor force, you're told, "you're over-qualified". That is too often the polite way of saying "you're too old".

What a waste!! In this time when Americans are trying to change their wasteful habits, why are we wasting our most valuable resource, the older worker?

In early 1978, there were over 4 million older persons needing money and/or activity who wanted to work but were unemployed. The american society is not adjusting quickly enough to the mounting number of older persons able and willing to continue working.

The Work in America Institute's in-depth report has been provided to the 1981 White House Conference on Aging for the information of delegates. It is one of a number of studies on a subject attracting new attention.

Since American's working-life potential has been extended by five to ten years, hiring, retirement, and related practices traditionally applied to persons under 45 now are appropriate for those 50 and over, the American Institute, a private nonprofit organization, argues. Going further, it proposes that employers design a variety of jobs and work arrangements for older people. These could include part-time positions, job sharing and flexible time schedules. Employees staying on past 65 not be expected to accept less than their younger fellow-workers in health coverage, vacations, sick leave and other benefits, while more flexible benefit arrangments should be developed for those choosing part-time work.

An employer opening a new plant or office, the Institute says, should try to trai current employees, including older ones, before going outside to hire a work force.

Another study, by the U.S. Labor Department Office of Research and Development, cited evidence that discrimination against older workers continues more than 10 years after passage of the Age Discrimination in Employment Act.

The Labor Department monograph, Employment-Related Problems of Older Workers, also said that employers, now in most cases prevented by law from requiring employees under 70 to retire merely because of age, will have to develop more objective criteria for determing the employability of senior workers.

Research findings, it said, indicate that older workers score as high as their juniors in job performance and productivity. But it said employers appear still to be largely ignorant of such recent research.

Another finding was that much early retirement is not voluntary. In one survey by Social Security, 55 percent of men who stopped work between 62 and 65 said they would have worked longer if they could.

Management should be encouraged to recall retirees for consulting assignments or temporary work— an economically sensible way to handle seasonal or peak demands.

The work in America Insitute titled its study "The Future of Older Workers in America: New Options for an Extended Working Life". The 18-month inquiry focused on the demographic, social and economic trends expected to emerge in the 1980's.

The number of people in the United States aged 65 or older is projected to increase from about 24 million to more than 31 million in the next 20 years, the report notes. The death rate in the over-65 group has dropped 14 percent in the past decade, resulting in a life expectancy of 15 years at age 65, 10 years at 74.

At the same time, the compilers of the study found indications that the trend of older persons to stop work, which has been growing for decades, now may be slowing and could reverse.

There is a man in a small town in my home state of North Dakota who turned 69 in June. He has been a printer for 34 years and has never missed a day! That is astounding and exceptional. However, if you consider the "older worker" to be 50 plus, over the hill, beseiged by medical problems, undependable and, after all, "he certainly

doesn't have many years to give the company", you're wrong, Mr. Business Man! My man, the printer, has been an "older worker" for nineteen years and never missed a day. And that my friends is not astounding and exceptional. Good work habits, dependability, better attendance, health and safety records - are proven attributes of the older worker.

It pleases me greatly to be able to tell you that since June of 1977 through August of this year, the Seek-A-Senior Employment Referral Program has counseled 1490 people over 50 and placed 488 of those in full or part-time employment. I am also pleased to report that as of May 1, 1980, the Seek-A-Senior Program has been funded for twelve months by a Department of Labor grant, Title II-B, State Services administered through the Office of the Governor, CETA Division. It is due to the wonderful support of you, Senator Rubin, Ms. Bumgardner, Mr. Bryan, John Zuidema, Marvin Lare, Director, Fletcher Spigner, my past supervisor, Sam Waldrep, and all of you from the various agencies here today, that Seek-A-Senior is still working. Your kind words of encouragement and letters of endorsement were instrumental in securing funding and keeping me from giving up.

On behalf of the R-LCOA and the older Americans we serve, my deepest thanks, and my hope that you will continue to "champion the cause" of the older worker not only this month, but each month and each month hereafter.

Thank you.

Ms. Betty Gardner
Advisory Board and Committee
Lower Savannah Council on Government
Aging Programs
1118 Richardson Road
Barnwell, SC 2o812

Ms. Gardner's testimony offered comments obtained from multiple sources: the hospital, the home setting and the physician's office.

She identified the following primary needs of the elderly:

1. Help for Social Security recipients on their medical bills
2. Increased transportation
3. More home delivered meals
4. More homemaker services
5. Need to establish a program of health maintenance within the home, including mental health counseling.

Ms. Gardner had drawn up an excellent chart which showed the average expenses of a senior citizen on Social Security in the amount of $258.00 per month. She stressed the point that it is better to have an income of $257.00 per month than an income of $258.00, as the recipient of the $257.00 is eligible for Medicaid benefits which will pay for a large percentage of the medications and doctors visits, whereas the recipient of the $258.00 is over the "cap," and eligible for Medicare only which does not provide coverage for medicines.

She emphasized the need for home health maintenance. Skilled nursing care in the home is made almost impossible due to the interpretation of the Federal guidelines by Blue Cross and Blue Shield.

Senator Rubin assured Ms. Gardner that this is our ultimate objective to provide medical services on the home level. He thanked Ms. Gardner for her well-prepared and detailed presentation.

(Full text of written statement on the following pages).

TESTIMONY PRESENTED

TO

THE SOUTH CAROLINA

STUDY

COMMITTEE ON AGING

Senate Chamber
State House
September 12, 1980

By: Betty Gardner
1118 Richardson Road
Barnwell, SC 29812

I would like to offer comments and observations obtained from multiple sources - the hospital, the home setting, and the physicians office.

I have worked as a registered nurse in rural hospitals in the Lower Savannah area for many years and continue to relieve periodically on weekends. For seven years, I worked as team leader in Barnwell County for Home-Healtr Services with DHEC and what I learned about our elderly population would fill several books! At the present time, I am an assistant professor at the USC-Aiken school of Nursing and have the opportunity to take the nursing students into the hospital area where they observe first hand the effects of age, illness and poverty on our elderly population. I also work part-time as a Family Nurse Practitioner with Dr. Michael Watson in Bamberg. Much of our clientel are above 60 and I have ample opportunity to identify the numerous needs of this age group. Last and certainly not least, I represent the Advocacy Committee of Lower Savannah Council of Government, the Aging Program. There is no way that I could adequately cover all the needs of the elderly in the alloted time, so I will speak briefly of the five primary needs that I have identified...

1. Help for Social Security recipients on their medical bills.
2. Increased transportation.
3. More home delivered meals.
4. More homemaker services.
5. To establish a program of health maintenance within the home to include mental health counseling.

Now I would like to briefly run over some facts and figures with you. I know that you are very familiar with all of these but I want to emphasize certain points. You may say it is strange that you say to live alone with an income of $257.00 a month is better than living with an income of $258.00. But with $257.00, the recipient is eligible for Medicaid benefits which will pay for a large percentage of her medications and for her doctors visits. It will cover the $180.00 deductible that has to be met if she is hospitalized. Now let's take $258.00 and very briefly look at this chart to see where the money is spent with a client who does not have access to Medicare to pay for their medicine. The rent on an apartment of any kind, even in my rural area would be at least $50.00 a month. The little shacks in shanty town run $25.00 and $30.00 a month. Then you have utilities (lights and water), that will run at least $30.00. If they have space heaters or fireplaces, which many of these older apartments have, a tremendous amount of energy is wasted. They will spend about $50.00 a month for gas in cold weather. Older people become colder earlier than young people, so they

start burning their heat earlier in the year and burn it later in the spring. I would like to point out here that one area where the elderly are really taken advantage of is buying wood because many people who deliver wood to them will charge $30.00 for a pick-up load and they have given them scrap lumber off of torn down buildings, dead limbs out of the woods, materials that will burn rapidly and will not produce slow, long lasting heat. So they are going to burn $50.00 worth one way or the other in gas or wood. Their medicines are going to run $55.00 to $70.00 a month. If they are lucky, they can get to the doctor's office every two months, but some of them cannot get there that often, this is roughly $15.00 for the office visit, $5.00 for the hemoglobin, $5.00 for urinalysis and maybe another test which totals roughly $24.00. This would be $12.00 per month for transportation to come in from a rural area, they charge anywhere from $4.00 to $7.00 to bring a person to the doctor and to get their medicine. This doesn't even take them in to get food, to get their check cashed or anything else which we'll go into later. Now, by my figures, this has already come to $224.00 and that means that this person only has $34.00 left for food. You may say, but Mrs. Gardner, there are a lot of low rent housing projects that these people can live in. True, or if they got into a low rent housing project they are assessed about 22% of their total income for their rent which would run $57.00. They would not have to pay utilities or heating, and they have no air-conditioning in the summer time. These apartments get terrifically hot and you've read in the papers of some people having had heat strokes and dying in hot apartments with no fan or anything during this heat wave. They still have their medicines to buy, doctor's bills and their transportation costs. So we still have $147.00 of outgoing expenses. Out of this, they might could get maybe $12.00 to $15.00 a month free food stamps, so they would maybe have $123.00 left for 30 days to buy all of their food, to buy any tooth paste, hair dressing, vaseline intensive care lotion, etc. The elderly's skin is very dry and many of them will have problems if they don't use some sort of lubricant on their skin. They have no money left to pay life insurance premiums, or to buy eye glasses, (if they have cataracts you know they have to wear glasses). If their denture or hearing aid breaks, how are they going to get them repaired? Now why do they need help with their medical bills? Let's very briefly look at this chart which I have prepared for you so you can see why the people who do not have Medicaid cards are having such a very difficult time. Medicare provides no coverage for medicine at all. Elderly people usually have between 4 and

7 diagnoses. We'll use an 80 year old lady , living alone who has 4 diagnoses. One is ASHD, which is arteriosclerotic heart disease, 2) she has hypertension, 3) she has generalized arthritis, and 4) she has glaucoma. First, her physician started her out on Indocin 3 times a day which was 100 capsules a month that ran her $19.00 a month. But after 2 months, she did not respond well to this, she was still having a terrific amount of swelling, pain and could hardly ambulate about her house, so he swiched her to Naprosyn, which is a twice a day dosage drug. This would cost, for 60 tablets a month, at least $24.00 or more. She has a decreased hemoglobin and a very poor appetite. You can frequently find in the elderly who live alone, that they are depressed a lot and this accounts for poor appetite. Anyway, he gives her a vitamin and iron preparation which will run her $4.50. Why does she need the Lasix? To control the fluid volume in her body which controls her blood pressure and keeps her from going into pulmonary edema or congestive heart failure. Next she needs Inderal 4 times a day, that's 120 tablets a month. Inderal is given as a help in bringing blood pressure down because it is what we call a beta blocker and it blocks certain receptors. And this is important for her to take. It also regulates her irregular heart beat. This is another $7.00 a month. Now, even with the Naprosyn that the physician has put her on, with normal wear and tear of being up on her feet all day, she is going to have some aches and pains from normal age deteriation in her joints. For this she is going to use Ben Gay, probably 2 tubes a month. That's going to run her another $5.00. Now we're down to her eye drops. Most people with glaucoma will have to have 2 prescriptions filled for eye drops. One is going to run $4.00, the other will run between $7.50 and $10.00. We'll figure in $10.00 because a lot of places charge this much. My total amount that I have come up with is $65.00 to $70.00 for just this amount of medication. In case the Inderal ceases to work, for blood pressure control, she is going to need an anti-hypertensive drug added, which is going to be an additional expense. I thought by breaking it down to dollars and cents that you could see why with the cost of medicines, the elderly's money just doesn't go very far. There are some pharmacists, God Bless their souls, that have tender hearts toward the elderly and they will allow the patients who will pay them $25.00 or $30.00 a month towards their medicines to go ahead and get these required medications and they just keep adding and adding and adding. When the person dies, the pharmacist has lost a lot of money. You are not going to find too many people in this day of inflation who will deal with people like this. So this is

why we need to change the federal guide lines to include medications, prescription eye glasses and dentures for the elderly people.

Now the second area is transportation. Good gracious, you all up here in Columbia have lots of taxi's and even though they charge, at least you've got access to get back and forth. In my little rural town, we don't even have a taxi! We had one but I don't think it made enough profit that they could stay in business. And so how do my people get back and forth to the doctor's office? How do they get to places like the food stamp office, or to the VA office to see about benefits? The only way they have is to call these people that charge them $4.00 to $7.00 a trip and when they bring them in to the doctor, they only bring them to the doctor. Maybe if they don't have to wait too long there, they will pick up the medicines and get them refilled for them. If they don't do that, then they have got to pay that extra trip to come back to get their groceries and to get their check cashed. We have transportation vans in our area but we don't have enough of them. They can only come on specified days to take patients to the doctor, or to the grocery store. But we're not talking about a 50 year old person - we're talking about a majority of people 65-80 years old, the mean age being about 76 or 77. And the clients are confused. They forget what day the van is supposed to come to pick them up and so therefore, they won't be ready, the van can't wait because she won't get the people to their appointments on time. Another thing to remember is that they may be feeling really bad that day and can't get out to come. Many also are homebound. So these are some of the reasons why we need more transportation.

The third need is home-delivered meals. Now the federal regulations say, that only 15% of 25 congregate meals can be home-delivered. Do you know how many meals that is out of 25? That is 3. How are you going to determine what 3 people in an area are going to get a home-delivered meal? We tried a congregate meal site in our county about 4 years ago and the Advisory Board of our Office on Aging voted against having the congregate feeding site another year for 2 reasons- 1. It was only a social place for the people and the clients were not screened according to need. One lady that I know had a homebound aunt. We could not get food delivered for that homebound aunt but the niece who was taking care of her was at the congregate site and eating her meal every day. (I was the visiting nurse for the homebound lady). I knew another lady who worked on a part-time job to supplement her social security income and she took her lunch hour to come eat! This was the type of people who were receiving the

services. It may have been valuable at that time but we could not see where it was benefiting the needs of our communities. And so we voted not to continue with the program. Now we do have a Senior Citizens center for socialization for the elderly. And we have vans to bring them in on specfied days for socialization. Now that this need is taken care of, I cannot understand why we continue to have federal regulations that say you can only have a certain percentage of your meals home-delivered.

This brings me to some statistics. Barnwell County in 1970 had 2204 elderly people over 60. I would say that we now have 2800 to 3000 because Barnwell has grown tremendously and a lot of people have moved in with elderly parents. How could we say, if we had a congregate feeding site with 25 meals out of 3000 people, who would get those 3 meals. That is only one per thousand. In Lower Savannah which covers six counties, we have 25,390 people over 60 years of age and 45% or nearly 11,000 of these persons are below poverty level. We have implemented, on a private basis in our county, 15 home-delivered meals for $1.75 per person. We now have volunteers to do delivery for these 15 but we have more people on the waiting list and can't get more volunteers because of the cost of gasoline. Even at that, 15 home-delivered meals out of a population of nearly 3,000 elderly citizens, is just a drop in the bucket.

We also have a need for increased homemaker services. Now you say, well you've got homemaker services in your county, you've got an Office on Aging and you have a Department of Social Services. That's true. They each have 3 homemakers who serve approximately 20 clients each month which comes to 180 a month. There again, out of 3,000 elderly in our community alone that's less than 6% who are eligible to receive homemaker services. Let me give you an example of how frustrating it can be to deal with inadequate services. Just when our Office on Aging had been established I was seeing an elderly couple in a rural area. I'll call them Yank and Annie Laurie. They each had multiple medical diagnoses. The main thing I was seeing Yank for was a bad toe almost gangreneous, from a poor circulation. His wife, Annie Laurie was 10 years older than he, being about 84 at that time. She was very sweet and kind, but very confused mentally. They were both illiterate. I tried every teaching method that I had ever used to reach these people to get them to take their medications properly. I could not get them completely off of salt because every time I would move the salt box Annie Laurie would go find it again. Because I didn't have anyone to cook their meals, I figured salty food was better than no food at all. They were taking all their medicines wrong or not at all. I

coordinated with the physician and got their medications changed to a twice a day dose, and devised this plan in desperation!! I put their put their pills each in a separate little box and cut out a picture of a man's face and put it on Yank's box and put a woman with a lot of hair on Annie Lauries box so they could keep the medicine separated. On the morning medicines, I put tape on the tops of the bottle and drew a smiling sun face like the rising sun coming up. They knew to take these at breakfast time. And on the night bottles, I drew a moon and stars so that they knew that at bed time, that's what they would take. (It worked!!) Finally when we got our Office on Aging, our director sent a homemaker in 3 days a week and with her buying and preparing their food, with the health teaching that I gave her and her implementing this, we were able to maintain Annie Lauries blood pressure within a safe range and we maintained these people at home for an additional 18 months. Those were 18 months that our taxes did not have to support them in an institution.

Now this brings me to the need for home health maintenance. Interpretation of federal guidelines by Blue Cross and Blue Shield for skilled nursing care in the homes are unreal. Now let me tell you it's unreal because for 7 years I dealt with those guidelines. If you have a chronic condition that has just stabilized, like getting a blood pressure within a normal range, you can't follow this patient any longer to see if the blood pressure will remain stable, or if the senile person will follow your health teaching without you. They will not pay for any screening for prevention, either. Also, if you have a terminal illness, like cancer, you don't need a catheter, a feeding tube or wound dressings, you can't go in to see that patient as their physical condition does not qualify for skilled care. They will not pay for counseling or support to the family or for nutritional guidance. These strigent guidelines are unreal. Many of the elderly in our communities in South Carolina could have better health care by having a home maintenance type program, where an RN or either a Nurse Practitioner could go in one time a month and check their blood pressure, their blood sugar, and their urine. She could also teach a homemaker/home health aid combination type person to do many things. If they needed personal care, give them the personal care. She could also buy their food, cook their meals and help with giving them the proper medications. Also where they have had strokes, Medicare will only allow you X number of visits to go in, once the patient is "stable", you can't go back, even though your patient may not be able to walk or talk or do anything for himself. This homemaker/home health aid could help with

exercising the patient to keep him from getting contractures and also help with ambulation to restore him to an optimum level of skilled care. The waiting list is very long. And if you try to put somebody like Annie Lauri in a nursing home facility, you might as well forget it because that's intermediate placement and the lists are longer than your arms and legs combined. But just think if we could implement a program like this or ideas with increased transportation, how much our tax dollar could be reduced by funding some of these programs, as compared to the alternative of institutionalization.

In closing, let me tell you about Miss Ellen. She was one of the first to go to the congregate meal site that we had in our county. Before that, the nurses would go in twice a week for a visit but before doing anything elso, like checking her heart or her blood pressure, we would put on something for this lady to eat because she was not able to cook and stayed alone. After we checked her but before we were ready to leave, we made sure that there was ample wood brought in from the wood pile and stacked on her porch so that she could reach it to put into her little wood burning stove. So when we got the congregate meal site, for about two months she was able to hobble onto the van and go. But then travel time there and back and the socialization was more than her frail health could take so she had to stop going. (Even then, she couldn't get a home-delivered meal.) She ultimately developed cancer of the liver and died but she did get to stay at home until two weeks before her death, when she became hospitalized. I went before the Commission on Aging and presented this lady's case as an example to get home-delivered meals in our county. Naturally, I was turned down. The Federal regulations still say we can't have them. Miss Ellen had told me numerous times, "Mrs. Gardner, I never had no schooling much, but I love the Lord and I read my Bible every night. I give thanks every night for you nurses and my doctor because without you all, I would be put in a home. Promise me you will make them understand I would rather live my time here in my little shack than to be in a fine home somewhere. Let me die here with my dog and my belongings.

How many of our elderly in South Carolina are fortunate enough to reach their goal? Thank you for your time and your attention.

Edward W. Rushton, Executive Director
Orangeburg County Council on Aging
P. O. Box 1301
Orangeburg, SC 29115

In his statement Mr. Rushton offered suggestions how to have cost-effective operations so that State and Federal funds could be used economically and effectively for a large segment of the elderly population. He respectfully asked the Committee to consider strengthening senior citizen centers which hold great promise of reducing costs for quality programs. A comprehensive senior center is a facility which provides services and activities, staffed by experienced personnel, to help keep handicapped and needy citizens at home and out of institutions as long as possible. A center like this offers the elderly nutritious meals, homemaker services, recreational outlets, educational opportunities, advocacy protection, employment opportunities and many services.

In his opinion, declining enrollments in public elementary and secondary schools and a leveling off of college student registrations, should make educational plant requirements less costly at the present time and for the foreseeable future. This should release construction funds for senior citizen facilities, and Mr. Rushton appealed to the Committee to explore the feasibility of State and Federal aid for construction of comprehensive senior citizen centers.

Another need, which pops up at every Public Hearing of the Committee on Aging, is transportation. Mr. Rushton wondered why school buses could not be utilized for senior citizens when they are not in use for school purposes.

Senator Rubin told him that the Committee will pursue the points made by Mr. Rushton, some of which will involve vast expenditures, but he feels that some progress is made every year.

Mr. Chairman, Members of the South Carolina Study Committee On Aging:

I am Edward Rushton. For the past 4 years it has been my good fortune to serve the Orangeburg County Council on Aging as its Executive Director. After a tenure in the education profession for 47 years, which was an unforgettable association with children and youth, I am now finding my work with senior citizens another rich and rewarding experience.

Our council provides a wide scope of services - 16 of them - and these programs are available to 10,600 older persons living in Orangeburg County. Most of our offerings originate from a senior citizen center, while similar activities are provided in several satellite facilities. Our center serves as a rotary wheel around which the total program revolves and a hub from which activities and services emerge.

For the last three annual hearings of your Committee on Aging I presented the need for more adequate comprehensive senior citizen centers. My presentations centered upon brief aspects of a physical facility to enable older persons to come together to fulfill many of their social, physical, emotional and cultural needs; and, a description of service programs to be provided as justification for senior center facilities.

In my plea today, I shall shift emphasis from a rehashing of previous testimony which could sound like a "stuck or broken record" to a cost-effective operation so that state and federal funds could be used economically and effectively for a large segment of the elderly population.

Stereotypes die hard but few are as stubborn as outmoded images of the elderly: the decrepit man placed in the nursing home, the impoverished widow waiting for someone to transport her to the grocery store, the lonely oldster hoping that somebody will call or just drop by for a few minutes. These and other heart-rendering experiences are constant, real and dehabitating. Surely we must try to alleviate these situations for the well-being of our elders and do so at the most economical cost and in more

effective ways. Furthermore, we should act now because for older citizens tomorrow is today.

An urgent and serious economic crunch affecting all of us, especially the poor and needy, is inflation. Energy, housing rentals, food, medical supplies, and services, institutional care are a few of the necessities for which there is not enough money to meet these expenses. The cries of the elderly are heard almost daily and yet they have to live or eke out an existence somehow.

One more related difficulty is the fixed income syndrome. While costs are escalating and con-artists are attempting to fleece older folk, it is essential to advise and counsel senior citizens concerning the wise use of their money and to serve as advocates for them.

I have merely scratched the surface with respect to the help needed by an increasing number of older folk today. The situation over the years ahead portends to get worse. Therefore, I respectfully ask your consideration to strengthening senior center agencies that hold great promise of reducing costs for quality programs.

Permit me to illustrate. A comprehensive Senior Center is a facility that provides services and activities, staffed by knowledgeable and experienced personnel, to help keep handicapped and needy citizens at home and out of institutions so long as possible. A center administers these persons through nutritious meals, homemaker services, education and recreational outlets, employment opportunities, discount privileges for goods and services, advocacy protection, outreach, senior companion assistance and Green Thumb.

Research is gerontology has shown that when older people are active, interested in life situations, enjoy social relationships, engage in cultural undertakings, adhere to proper nutritional needs and participate in appropriate physical exercises they enjoy a healthier and happier existence, live longer and require less institutional

care. Furthermore, older citizens seem to want to stay close to friends, relatives and live so long as they can in their familiar settings. I submit that comprehensive senior citizen centers come close to meeting the needs of a large segment of the older population; thereby, reducing the need for institutional care and congregate living accomodations.

Obviously, there are not enough nursing homes and congregate living centers in view of the waiting list of persons who should be there. However, there are older persons in those institutions who do not need the extensive and expensive services provided because many of them can be served elsewhere. I refer to the mobile and the handicapped, and that's a major reason for establishing and maintaining comprehensive senior citizen centers. Furthermore, institutional care by the very nature of its purpose must be more costly.

I am, therefore, suggesting an option for meeting the needs of many older persons who do not require long-term institutional services but their needs must be met. Comprehensive senior centers for the mobile and handicapped elderly are being utilized successfully. Obviously, economy and cost effectiveness are exactly what I'm advocating. Regardless of the direction that South Carolina and the federal government decide to go, the ultimate choice should center upon cost-effective approaches. It is my opinion that tight budget allocations require a critical re-evaluation of options for essential services. Therefore, I trust that comprehensive senior citizen programs and services housed in adequate facilities will be funded fairly for what they can do well for the worthy citizens they have the responsibility of serving.

In view of the declining enrollments in public elementary and secondary schools and a leveling off of college student registrations the educational plant requirements should be less costly at the present time and for the forseeable future. This situation could release construction funds for senior citizen facilities. The older

generation of citizens deserve better physical quarters to make it possible to meet the urgent requirements for programs and services today and for the years ahead. I appeal to you to explore the feasibility of state and federal aid for construction and equipment for adequate comprehensive senior citizen centers.

Let us try to maintain life and wholesome living so long as possible in normal, natural settings. Otherwise the growing demands for institutional care with its attendant costs will become astronomical. The cost of adequate comprehensive centers with programs and services enumerated in this presentation are miniscule in comparison to other options currently available.

Another concern on the forefront for senior citizen needs is transportation. It pops up every time concerns for the elderly are addressed. The 1971 White House Conference on Aging cited this lack of mobility as one of the most serious problems facing older persons. All of us realize that lack of transportation is far more than a mere inconvenience for many older persons. It can result in poor nutrition, isolation and eventual deterioration in physical and mental health. In rural areas the situation is really accute.

In our county a modicum of transportation is provided by the Community Action Agency to bring a small percentage of Orangeburg County seniors to our center. Any other transportation on an emergency basis is available through DSS and personal automobiles.

A minor breakthrough in transportation fares for older citizens is now offered by commercial bus companies and Amtrak; however, this discount is no relief in getting to the grocery store or to a doctor's office a few miles away.

I am sure that you will continue to find a solution to the vexing transportation problem. In the meantime, I wonder why school buses could not be employed when they are not used for school purposes. These vehicles are in parking areas many hours each

day. Aren't buses the property of the State and must these vehicles be used exclusively for the transportation of school pupils?

Thank you, Senator Rubin and Members of the Study Committee on Aging for your commitment and dedication to all senior citizens in South Carolina. I am also sincerely appreciative of your generosity in permitting me to speak on behalf of our worthy and deserving older citizens of Orangeburg County.

Edward W. Kinsman
Executive Director

9/12/80

Thomas E. Brown, Project Director
Community Long Term Care Project
17 A Metro Center
Spartanburg, SC 29303

Mr. Brown gave a brief background of the Project and listed the major accomplishments of the Project in FY 79-80 which are 1) the approval by the HCFA (Health Care Financing Administration) of the 1115 Waiver to the State's Medicaid plan and the completion of the pre-operational activities necessary to begin the expanded services phase, and 2) the initiation of assessment and service planning services in the Project area (Cherokee, Union and Spartanburg Counties) for individuals who have long term care health problems.

The Project has adopted three policies which will be evaluated for their policy implications:

1. The first policy requires that assessment by the Project staff be accomplished as a prerequisite for nursing home admission for all Medicaid clients desiring nursing home care in the Project area.
2. The second policy addresses the issue of the appropriate location of care for individuals with long term care health problems. Determination of the need for nursing home services essentially is a two-step process:
   a) Initially, the level of care must be determined by the patient's physician. Individuals must be classified as either skilled or intermediate level to meet the medical necessity requirements for nursing home.
   b) The decision concerning location of care is one which is reached jointly with the patient, his family, his physician and the Project staff.
3. The third policy addresses the cost of the expanded services which are provided through the 1115 Waiver.

The Project has planned and will be implementing expanded community services; such as, medical day care, respite care, personal care, home delivered meals, home health services expansion, mental health services expansion, eyeglasses, dentures, preventive dental services and expanded

transportation. In addition to the new services, the Project has obtained a waiver of eligibility to provide Medicaid eligibility to those individuals in the experimental group whose monthly income is above the SSI level ($238 with a $20 disregard) and below the Medicaid nursing home cap ($714/month); i. e., these individuals who previously would be eligible for Medicaid only if they were admitted to a long term care institution will now be eligible to receive expanded community services and the current Medicaid services available outside of a nursing home.

Individuals who meet the following criteria may be assessed irregardless of income: must be an adult over 18 years of age, live in the Project area, meet the level of care requirements for nursing home admission or have physical and/or mental impairments requiring long term care services to assist with activities of daily living.

For participation in the Project, all clients must be Medicaid eligible (income under $714 nursing home cap).

With the Project in the expanded services phase, it is anticipated that approximately 1,800 referrals will be received annually. From July 1, 1979, to July 16, 1980, the Project received 980 referrals for assessment and service planning. Seven hundred and sixty-three (78%) were residents of Spartanburg County; 129 (13%) were residents of Cherokee County, and 87 (9%) were residents of Union County.

Now that the Project has entered the full operational phase with expanded services, we anticipate a great increase in the number of individuals who are at skilled and intermediate levels of care and who can be maintained in their home environment.

State funding to match Federal Medicaid and grant funds from the Appalachian Regional Commission is included in the S. C. Department of Health and Environmental Control Five Year Plan. A line item for the Community Long Term Care Project is on page 117. The Project is requesting State funding in the amount of $574,275 with carry-forward authority for any unexpended funds on June 30, 1981. This request is an increase of $273,000 over the current funding level of $301,275. The increase is needed to cover the increase in the number of clients participating in the Project, as well as anticipated annualized cost per client for individuals who were admitted to the Project during the first Project year.

With the implementation of the Project, a number of policy issues concerning the State's long term care system are being investigated:

1. Use of the Project's assessment instrument and process as a pre-screen for long term care services.
2. Development of a recommendation concerning the appropriate location of care for individuals with long term care needs.
3. Pricing and utilization of expanded community services to meet needs identified through the assessment process.
4. Expanded eligibility for community services offered to individuals whose income is above SSI and below the Medicaid nursing home cap.

Senator Rubin thanked Mr. Brown for the very good and important job he is doing. The Committee is looking forward to periodic reports and consultations with Mr. Brown. He added that it is his understanding that the Budget and Control Board has approved the increase of $273,000 which is very good news.

Presentation to the Study Committee on Aging

September 12, 1980

by Thomas E. Brown, Jr.

Director, Community Long Term Care Project

The Community Long Term Care project was mandated by the 1978 Legislature to conduct a pilot project of community-based services for the chronically ill and impaired adults in Cherokee, Union and Spartanburg Counties. The goal of the project is to gather information that the state can use to decide whether to adopt into its long term care system a case management/care planning service and other new community services. This information is aimed at determining client impact, cost effectiveness and implementation strategies.

The project receives policy direction from the Long Term Care Council, which was also mandated in 1978. The members of the Council are Mr. Virgil Conrad, Chairman, Dr. Robert Jackson, Dr. William Hall, Mr. Harry Bryan and Governor Riley, who is represented by Mrs. Sarah Shuptrine. During the past year, the Council met on 12 occasions. All of the members maintained a high degree of personal involvement and commitment to the project as demonstrated by their attendance and participation. This vehicle for interagency cooperation in a joint policy informing effort has been very effective to date and should be even more important as the project enters the full implementation phase.

The major accomplishments of the project in FY 79-80 have been 1) the approval by the Health Care Financing Administration of the Section 1115 Waiver to the State's Medicaid plan and the completion of the pre-operational activities necessary to begin the expanded services phase of the project, and 2) the initiation of assessment and service planning services in the project area for individuals who have long term care health problems.

The project received conditional approval of the Section 1115 Waiver request in November, 1979, and final approval in July, 1980. This approval by the Health Care Financing Administration allows the project to be conducted in a sub-state area and allows for implementation of new services, which might be tested and evaluated for future inclusion in the State's Medicaid program. The conditional approval resulted in a revision to the project to strengthen the research and demonstration methodology. This change involved the formation of a control group within the project area who will be admitted to the project for data purposes but who will not receive expanded services. The expanded services group will be like the control group and will be able to access all of the services provided through the project. The presence of these two groups will allow for the thorough analysis of research hypotheses which deal with client impact, cost and effectiveness of the new services. The project has adopted three policies which will be evaluated for their policy implications. The first policy requires that assessment by the project staff be accomplished as a prerequisite for nursing home admission for all Medicaid clients desiring nursing home care in the project area. This pre-screening function is extremely important to the proper utilization of all long term care services and will assist in interpretation of the project findings regarding the cost and effectiveness of the new services. The second policy addresses the issue of the appropriate location of care for individuals with long term care health problems. Determination of the need for nursing home services essentially is a two-step process. Initially, the level of care must be determined by the patient's physician. As you know, individuals must be classified as either skilled or intermediate level to meet the medical necessity requirements for nursing home. A second part of the

decision concerning the need for nursing home services deals with the appropriate location of care. Many individuals have available to them, either from their family or friends or from community agencies, appropriate services which would be able to support the individual in the community, even though that individual might be categorized as skilled or intermediate level of care. The decision concerning location of care is one which is reached jointly with the patient, his family and physician, and the project staff. The third policy addresses the cost of the expanded services which are provided through the Section 1115 Waiver. This policy allows the cost of expanded services for an individual to be up to 75% of the cost of institutional care at the level which is required by the patient. This cost is computed over a 90 day period of time.

The project has planned and will be implementing expanded community services. These services include Medical Day Care, Respite Care, Personal Care, Home Delivered Meals, Home Health Services Expansion, Mental Health Services Expansion, Eyeglasses, Dentures, Preventive Dental Services and Expanded Transportation. In addition to the implementation of new services, the project has obtained a waiver of eligibility to provide Medicaid eligibility to those individuals in the experimental group whose monthly income is above the SSI level and below the Medicaid nursing home cap; therefore, these individuals who previously would be eligible for Medicaid only if they were admitted to a long term care institution, will now be eligible to receive expanded community services and the current Medicaid services available outside of a nursing home. Our preliminary estimates are that approximately 50% of the clients in the expanded services group will fall under the waiver of eligibility. These clients will be required to pay a small fee to participate in the project. The fee ranges from $9.60 to $28.50 per month, depending on the client's income. The clients are paying the fee regardless of the amount of services utilized, as long as they remain in the community. Once an individual in this category is admitted to a nursir home, the normal procedures for application of monthly income towards the cost of nursing home care would be followed. We presently have 4 clients in the expanded services group who are contributing.

To receive assessment and service planning services through the project, an individual must be an adult over 18 years of age, live in the project area, and meet the level of care requirements for nursing home admission or have physical and/or mental impairments, resulting in functional dependency which requires long term care services to assist with activities of daily living. Individuals who meet these criteria may be assessed irregardless of income. For participation in the project, however, all clients must be Medicaid eligible (income under the Medicaid nursing home cap of $714/month) and must meet the established resource requirements. Now that the project is in the expanded services phase, we anticipate that approximately 1800 referrals will be received annually, and, out of that group, approximately 1400 will be randomized into either the control group or the expanded services group. Approximately 400 clients should be receiving expanded services by June, 1981. Progress to date suggests that these estimates are attainable. As of August 29, 1980, the project had received 203 referrals, and 46 clients were participating in the expanded services group.

The second major accomplishment last year was the initiation of assessment and service planning activities. From July 1, 1979 - July 16, 1980, the project received 980 referrals for assessment and service planning. 763 (78%) were residents of Spartanburg County. 129 (13%) were residents of Cherokee County, and 87 (9%) were residents of Union County. Out of the total referrals, the project staff performed assessment services for 741 individuals (76%). The remaining individuals did not receive assessment services for one of the following reasons:

1. Died before assessment - 87 (9%)
2. Chose not to participate - 94 (10%)
3. Inappropriate for assessment - 34 (3%)
4. Moved out of the project area - 24 (2%)

Special analyses were accomplished on 290 patients which the project served between January and June of 1980. The median age of this group of patients was approximately 80 years of age. 93% were age 60 and above. 10% were age 90 and over. This age distribution indicates the aging of the older population, which is known as the old, old population and their demand for long term care services. Analyses which were accomplished dealt with the presence or absence of personal care and household supports, given varying levels of impairment and disability. Of the 290 patients, 73% had either moderate or severe disability, and 38% of the total group had limited or no personal care and household supports available to them. Other needs, such as bathing, medication and meal preparation, were also reviewed. 42% of the group were dependent, in terms of their ability to bathe themselves, and also had limited or no support system to provide this service. 48% were dependent in their ability to monitor their own medications, and also had limited or no supports available to them. This problem often is a contributing factor to the need for nursing home care.

To determine the impact of the project to date, one must review the results of the assessment and service planning activities in terms of the level and location of clients participating in the project. 89% of the 290 clients, or 258 clients, had acute or chronic illnesses, which qualified them as either skilled or intermediate care, which is necessary for nursing home admission. 32 clients (11%) were classified as less than intermediate level of care. Of the 258 clients who met level of care requirements for nursing home admission, 88% were recommended for nursing home placement and 12% were recommended for community placement, even though their level of care would have qualified them for nursing home admission. Of the 12% who were recommended for community placement, 29 were at intermediate level of care and 3 were at skilled level of care.

Our experience to date is that clients who are referred to the project and who are presently residing either in a nursing home or hospital have higher probability of needing nursing home care than those who are referred to the project and who are residing in a community-setting. Within the study group of clients, 166 were referred to the project from an institution. Of that group, 9[illegible]% were recommended for skilled or intermediate care in a nursing home, and the remainder were recommended for community placement. Of the individuals who were referred to the project and were residing in the community, 26% who met the level of care requirements for nursing home admission were recommended for community services. These data illustate that clients who have an acute illness requiring hospitalization are more likely to require nursing home admission; however, there is a possibility that a number of these individuals can be served in the community. Also, individuals who are presently in the community and have long term care health needs are and will be more likely to remain in the community with additional services which might be available to meet their needs. Now that the project has entered the full operational phase with expanded services, we anticipate a great increase in the number of individuals who are at skilled and intermediate levels of care and who can be maintained in their home environment.

As had been indicated, the location of the patient has a great deal of influence on the needs for continuing service. Based on the source of referral for this same 290 patients, it is evident that a majority of the patients were located in the hospital at the time of referral to the project. By source, the referrals were as

follows:

1. Hospital - 140
2. Nursing Home - 14
3. Physician - 1
4. Department of Social Services - 98
5. Health Department - 12
6. Council on Aging - 1
7. Family or Friends - 20
8. Self-Referred — 4

With implementation of expanded services, we anticipate an increase in the number of referrals, as well as an increase in the number of referrals for individuals who have less severe long term care needs. The requirement that assessment by the project be a prerequisite for nursing home admission for Medicaid eligible individuals in the project area has provided the project with access to 100% of the Medicaid eligible individuals needing nursing home care in the project area. This requirement also has meant that most of the clients which have received project services during the first year of the project have been on the more severe end of the disability and impairment scale. Presence of the project as a pre-screening mechanism for nursing home admission in the project area is an important policy issue which will continue to be evaluated.

The State funding to match federal Medicaid and grant funds from the Appalachian Regional Commission is included in the South Carolina Department of Health and Environmental Control Five Year Plan. A line item for the Community Long Term Care Project is on page 117. The project is requesting State funding in the amount of $574,275, with carry-forward authority for any unexpended funds on June 30, 1981. This request is an increase of $273,000 over the current funding level of $301,275. This increase is needed to cover the increase in the number of clients participating in the project, as well as the anticipated annualized cost per client for individuals who were admitted to the project during the first project year.

In summary, I would like to say that the project has received approval from the Health Care Financing Administration of the Section 1115 Waivers, and has completed the preoperational activities necessary to initiate the project experiment on July 17th of this year. Secondly, during the past year, the project staff has conducted assessment and service planning activities for over 740 individuals. The data concerning the individual client characteristics are presently being analyzed to determine the demographic, medical, functional and mental characteristics of individuals who have long term care health needs, as well as to determine how well these characteristics predict the need for the use of community services. And lastly, with the implementation of the project, a number of policy issues concerning the State's long term care system are being investigated. These include the use of the project's assessment instrument and process as a pre-screen for long term care services, development of a recommendation concerning the appropriate location of care for individuals with long term care needs, the pricing and utilization of expanded community services to meet needs identified through the assessment process and lastly, the expanded eligibility for community services offered to individuals whose income is above SSI and below the Medicaid nursing home cap.

We are appreciative of the assistance and support of the Committee in the past, and maintain a great deal of optimism about the future of the project. Thank you for the opportunity to discuss our progress.

W. J. Castine, Chairman
SCREA Legislative Committee
3519 Raven Hill
Columbia, SC 29204

Mr. Castine expressed the appreciation of the members of the S. C. Retired Educators Association to the Committee for their efforts over the years in behalf of the elderly in this State.

His statement addressed the following:

1. Inflation - This continues to be a major threat to people on fixed income.
2. Cost-of-Living Increase - The S. C. Retirement System will fund a 4 percent cost-of-living increase in benefits for retirees. The SCREA recommends that at least another 2 percent be provided to the retirees through general appropriations.

(Prepared statement on following pages).

Senator Doar commented that one of his constituents, a retired schoolteacher in Georgetown who has taught him and worked long and hard for 40 years, told him how little she was receiving through the S. C. Retirment System. He was amazed "at the pittance" she was receiving and he wholeheartedly agreed with Mr. Castine's remarks in behalf of retired educators. He said that although we have made some progress in that area, considerable more progress needs to be made, and he hopes that the Committee will work in this direction.

Senator Rubin agreed with Senator Doar and said that he hopes that they can do something in this area. Of course, you have to realize that you are competing with current employees.

THE SOUTH CAROLINA RETIRED EDUCATORS ASSOCIATION

Statement to the South Carolina Study Committee on Aging

By: W. J. Castine, Chairman
SCREA Legislative Committee
September 12, 1980

The members of the South Carolina Retired Educators Association are grateful to the Study Committee on Aging for its efforts over the years in promoting and getting passed legislation that has helped make life better for older citizens of South Carolina. Much has been achieved, but there are problems and situations which require our further study and solution.

Inflation continues as a major threat to the buying power of persons living on fixed income. Retirees find it more and more difficult to maintain the standard of living to which they have become accustomed. Such items as food, health care, utilities, etc., which constitute most of the budgets for older citizens, are the items that seem to advance more rapidly in costs.

It is our understanding that the South Carolina Retirement System will fund a 4 per cent cost of living increase in benefits for retirees. The South Carolina Retired Educators recommend very strongly that at least another 2 per cent be provided for retirees through general appropriations. We further recommend that when any changes or improvements are made in benefits to active teachers and state employees that the same or equivalent benefits be granted to retirees.

Retired educators continue to be interested in the welfare of all older citizens. Therefore, we pledge to you our support of other legislative programs designed for that purpose. We will work very closely with other organizations and groups. We support completely the legislative program of the Joint State Legislative Committee, NRTA/AARP. We believe that by working together we can achieve further benefits for our older citizens who have given so much to South Carolina.

Harold G. Dye
American Assoc. of Retired Persons (AARP)
983 Nabors Drive
Charleston, South Carolina 29412

Knowing that funding for many new projects will be extremely difficult to get during the next legislative session, Mr. Dye presented four suggestions to the Committee which should save the State money, or at least will be of minimal cost to the State:

1. Compile a "Guide to Human Services" which would list the multiplicity of city, county and State organizations, commissions, departments and committees set up to do a specific job to help the elderly or needy, in one section of the telephone book. In Harrisburg, Pa., and Lexington, Ky., they came up with a good solution. They persuaded one agency, such as the Chamber of Commerce, to compile all these numbers, and then they asked Bell Telephone Company to publish this information. He enclosed a sample from the Harrisburg, Pa., telephone book. Printed on green paper, it is called "The Green Section." Extra copies of this "Guide to Human Services" could be distributed to churches and senior citizen groups. The cost to the State would be small, but the value for all citizens great.
2. On transportation, he listed bus routes which were set up years ago, taking people to and from work or to the downtown area, but seldom to new shopping centers or new growing suburban residential areas. Also, to be considered is the fact that many elderly fear being mugged or even killed when riding a bus and refuse to use one. Some cities have started to subsidize taxi fares for the elderly. Mr. Dye investigated several and found that they pay one-half of the taxi fare for seniors; the taxi company collects that balance at the time of the ride from the passenger. In most cases, the city or county is able to get back the money used as a subsidy for such rides from UMTA in Washington. Churches also like to assist their elderly and by using volunteers with cars—reimbursing owners for costs—or using their own minibuses, they can assist with the transportation problem.

3. Housing Problems - This suggestion, Mr. Dye said, would cost neither the State nor the Federal Government any additional funds, yet would solve the problems of 10 percent (or 25,000 individuals) of the elderly in South Carolina. In a few areas of this country they are offering a new source of funds to senior citizens to help them keep their homes and enable them to stay out of nursing homes; i. e., a housing annuity, or a revenue equity mortgage. The elderly home owner transfers title to his home to an independent mortgage association in exchange for a guaranteed annuity, either for his life or for a specified number of years. The association then is required to maintain the home up to a specified standard of safety and quality, while paying the elderly tenant a regular monthly annuity.

   Mr. Dye urged the Committee to look into this matter.

4. Physicians who refuse to accept patients on Medicare or Medicaid. He feels that such refusals should be made illegal for any physician licensed by our State, or, if this should be too drastic, have the Commission on Aging publish lists in each county of all physicians who will accept assignment of Medicare benefits and of those who will accept Medicaid patients.

   (Mr. Dye's complete text as well as a "Guide to Human Services, with an instruction sheet on how to compile such a "Guide" are on the following pages).

Dr. Parrish wanted to know which one of the four suggestions does Mr. Dye consider the best one.

Mr. Dye answered him suggestion No. 1.

STUDY COMMITTEE ON AGING HEARING - Sept. 12, 1980

By: Harold G. Dye, Charleston, S.C. for American Association Retired Persons AARP)

I have a few suggestions to make to this committee, but before I start I would like to commend its members for their long, continued interest in the problems of the elderly, and for the many fine bills and regulations you have sponsored to assist them with their problems. The AARP members are proud to work with you on a continued basis.

We are aware that the 1981 Legislative session will be a tough one to get funds for any new programs, no matter how desirable. Money will be tight, and we appreciate the difficulties additional aid for the elderly will be to get passed, even when the proposition seems most desirable. But, I would like to suggest some changes that should save the state money, ~~and others~~ where the cost will be just minimal for the state.

One. When in need the elderly (and many not so old as well), often find it near impossible to contact the right person, agency, or bureau to get the help they seek. South Carolina, like our federal government, has a multiplicity of local, county, and state organizations, commissions, departments and committees set up to do specific jobs to help the needy and the elderly. I am sure that most, if not all, the workers in each of them is dedicated at doing a good job, and giving assistance to those asking for their help. In most areas of the state, to locate such assistance, you use the phone. I am asking each of you, when you go back to your home, imagion you are one of those elderly needing help, then try yourself to locate the right person by phone to assist you. Look in the front of the phone book. Look in the yellow pages. See just how difficult it is to find the number to call, where they answer your questions for help you seek. If you get the wrong department, they will try to help, but never seem to know what the right number you should call. Believe me, it is terribly frustrating for an old person. State employees are willing to help, but they know so little of any other offuce , not in their jurisdiction. Nowhere is there a directory available to either you, or to them, listing helpful numbers under all possible headings, and too frequently, the heading is that of the agency paying the phone bill, and with no relationship to the services being rendered.

Now this problem is not one in South Carolina alone. It is a problem in many areas of our country; a few tackling it, have come up with good solutions. Oh, what ahelp that is to many of the needy and elderly. In Harrisburg, Pa., and in Lexington, Ky., for example, they came up with this solution. In each phone book area, they have secured some agency - as a Chamber of Commerce - to compile all this information together. They have then persuaded the Bell Telephone Co. to publish this information together. Using green paper, it is called "The Green Section", and is headed as a "Guide to Human Services". In Harrisburg they have in addition set up a special number, called and listed both as "Help Line" number, and "Information and Volunteer Service Number". Calls are answered by a knowledgeable individual, who will put the caller in touch with exactly the right person or department the caller needs to contact. They also have extra copies of this Green Section printed up, and arrange for Churches, Ministers, Senior Citizen groups, and othersto obtain copies to use as they find the need. Perhaps the S. C. Commission on Aging could foster a similar section in each phone book area of our state. The cost to the state would be small, it's value great. I am attaching to a copy of my presentation, a sample of Harrisburg "Green Section.

Two. There is the problem of transportation. Many no longer able to drive for physical reasons, and/or not owning a car, face a very real problem in getting to and from the doctor's office (no house calls anymore, of course), to the store, to the labortary for t

to Church, or to visit a friend. In cities they may have buses, but their routes are usually ones set up scores of years ago, to take passengers to and from work, or to the downtown stores - seldom to the new shopping centers where most of the customers prefer shopping today. Executives in charge, often engineers, either lack the authority, or the initiative, to try new routes to the fast growing suburban residential areas, to shopping mall, or to a new industrial complex where many now work - then complain about the vast amount of money they lose each year on their franchise. But even when available, I find large numbers of the elderly afraid to ride the buses in any case. The fear of many older women is of being mugged, fear of being raped, fear of being killed, While this fear is not based on any sound statistical basis, it is very real to many, so that they absolutely refuse to ride city buses, even where available. Now some cities recognizing all these problems, are taking some of the subsidy money, and are subsidizing taxi fares for the elderly. I investigated several, where they give one half the taxi fare for seniors, with the taxi company collecting the balance at the time of the ride, from the passenger. In most cases the city, or county, are able to get back the money used as a subsidy for such rides, from UMTA in Washington.

Another solution I found used in a few cases, was that of recognizing the desire of many Churches to assist their own elderly, then organizing all the Churches in a given area to work together, using volunteer drivers, and volunteer dispatchers, to provide transportation at specific times each day, to any senior citizen needing it. Some use private cars, reimbursing owners for costs, some use Church provided mini-buses.

Then there are those elderly persons living way out in the country, 25 miles or so from town. In some areas, by modifying rules, they allow such seniors to ride the School buses along with children, on their regular runs. They are left off in the town where the School is located, then after School, they are furnished a ride back home. In some places, they also allow these elderly persons to eat their noon meal in the School lunch room, paying the same price as the teachers pay, and eating with teachers and children. Of course Federal funding pays part of this cost.

Three. Housing problems of our elderly have consumed much thought and time of this Committee in the past, and many of the problems still remain to be solved. We all know that vast amounts of money have already been spent, that much of it seems to have been poorly spent, and that the problems are at least as great today, as they were ten years ago. With the tight 1981 budget, you may question if anything else can be done at this time. Let me mention an alternative, that would cost neither our state or the federal government any additional funds, yet would solve the individual problems of 10% or more of our elderly, or 25,000 individuals elderly in S.C.

A substantial number of the retired older citizens of the State are home owners, with a large proportion living in the suburbs, the small towns, or in the country. Nearly all love it there, and hate to even think of leaving their old home until taken by death. A third of those home owners in 1979 had incomes below $5,000, with 15% subsisting on less than $3,000 a year. With the soaring prices of food, clothing and utility costs, there is nothing left to maintain their biggest asset - their home. It's value is depreciating every year despite inflation, because of this; and too often no longer meets minimum safety or health standards. In a few areas of our country they are doing something very constructive about such a problem, while at the same time saving the county and/or the state money otherwise needed to keep them in a nursing home, where they might otherwise end up. These older citizens are actively solicited and informed about a new source of funds - a housing annuity, or a revenue equity mortgage. The elderly home owner transfers title to his home to an independent mortgage association in exchange for a guaranteed annuity, either for his life, or for a specified number of years. The association is then required to maintain home up to a specified standard of safety and quality, while paying the elderly tenant a regular monthly annuity. The

tenant can then live in reasonable comfort and security, helped if needed by a Home Care Aide, or by regular visits by a Health Department nurse, close to his old friends and relatives, and out of a much more expensive nursing home - too often the alternative. Members of this Committee, members of the Legislature, we need legislation to be enacted in South Carolina that will allow housing annuity loans, and reverse annuity mortgages, as a means of allowing more elderly home owners in our state to spend their closing years in the homes they love, instead of off in a strange and frightening nursing home among strangers.

Four. Just one more quick suggestion, and I am through. All over our State we who are receiving Medicare, and those less fortunate who are on Medicaid, face a somewhat amazing problem. We have hundreds and hundreds of physicians in our state. If they are graduates of our medical colleges, we have subsidized their education up to a hundred thousands of dollars. Then so they can avoid unfair competition, and to better protect the citizens, we license each of them - which prevents any others (no matter how qualified) to prescribe medicines, to perform even simple operations, and to charge such patients any amount or sum they feel like charging, or in some cases they think they can collect. Despite all this, we allow these licensed physicians to turn down poor patients who we are providing Medicaid benefits; and to refuse to accept assignment of Medicare benefits for elderly patients.

It is time, we feel, that either such refusal be made illegal for any physician licensed by our state; or if that is deemed too drastic, for the Commission on Aging to publish in each County lists of all physicians who will accept assignment of Medicare benefits, and of those who will accept Medicaid patients. We have paid for their education with our taxes, we license them to keep out too great competition, surely we can insist they stop this discrimination.

I thank all of you for allowing me to make this presentation. Thank you.

guide to human services

This Guide lists Agencies grouped according to the problems that they handle. It is not an all inclusive listing nor does it list all the services which each agency offers.

If you need more information or if you need help identifying your problem, CALL HELP LINE, at INFORMATION AND VOLUNTEER SERVICES* 261–6010, ANYTIME during DAY OR NIGHT.

A United Way Agency

SURVIVAL NUMBERS

EMERGENCIES – For POLICE, FIRE & AMBULANCE
See inside front cover or dial 911 or "Operator"

CRISES & HOTLINES (24-hr.)
Crisis Intervention or Suicide Prevention
+(For Acute Mental-Emotional Stress)
Dauphin County 232-7511
West Shore-Holy Spirit Hospital 761-6013
Carlisle Area 243-6005

Poison Control Center
National Clearinghouse 301-443-6260
Call above number for your regional center

Information & Referral (I & R)
CONTACT Listening & Referral 652-4400

Runaway Hotlines "You Can Trust Them"
Nat'l. Runaway Switchboard 800-621-4000
Texas Runaway Hotline 800-231-6946

ABUSE-ASSAULT
Child Abuse Line (toll free) 800-932-0313
Parents Anonymous . . . . . Call CONTACT 652-4400
+(self-help group for frustrated parents)
Child Care Service Dauphin 255-2870
Cumberland 243-2020
Perry Co. 582-2131
Rape Crisis Center 238-7273
Women in Crisis 534-1101
or
Abused Women (in some communities)

DISASTER Community Disaster
8 AM to 5 PM 355-6990
Nights, weekends & holidays 355-4215
American Red Cross 263-3100
Civil Defense
TURN ON RADIO or TV! Do not use telephone

ADOPTION – *Local Agency* 123-4560

ANIMAL – *Humane Society* 564-3320

AGING SERVICES See "Senior Citizens"

ALCOHOL & DRUG
List here all counseling and treatment Centers.

BLIND & VISUALLY HANDICAPPED
See "Health"

CAMPS See "Recreation"

CHILDREN & YOUTH SERVICES
Child Care Services 255-2870
+(Neglected-Adoption-Day Care Centers)
* Family & Childrens' Services . . . 238-8118
Holy Spirit Early Intervention . . 761-5100

CONSUMER SERVICES
Better Business Bureau 291-1151
Bureau of Consumer Protection . 787-7109
Credit Counseling Service 232-8701
Governor's Action Line . . . 800-932-0784
Memorial Society (For Funerals). 564-4761

COUNSELING Personal-Family-Marriage-Child-Behavior Problems
* Catholic Social Services 299-3659
* Family & Children's Services . . . 238-8118
* Jewish Family Services 233-1681
Lutheran Social Services 626-1171
Parent Training . . . . Call Mental Health for S.T.E.P. or P.E.T. courses.
* Red Cross, American 234-3101
+(Military Families and Veterans)
Also, see "Crisis Intervention", "Mental Health" and "Self-Help Groups"

DAY CARE CENTERS
Call Child Care Services 255-2870

DEAF SERVICES See "Health"

DRUG PROBLEMS See "Alcohol"
Tipsters – Confidential. 949-6603

VOLUNTEER CENTER
Be a volunteer! Call 255-1100

EDUCATION Adult
American Red Cross. 234-3101
(CPR, First Aid Health Services)
Adult Evening School, Lanc. . . . 393-3871
Vocational-Technical Schools
Mt. Joy 653-2061
Willow Street 464-2771
University Center 766-3452
Penn State Co-op. Ext. Services . 249-7220
Children
List Nursery Schools & Learning Centers
Gifted Children
Capital Area Intermediate 761-6240
Handicapped
CONNECT Preschool Information 236-1133
Easter Seal Society 564-6500
Also, see "Schools" in Yellow Pages

EMPLOYMENT SERVICES or JOBS
Counseling-Training-Placement
List here all possible resources for adults, youth, handicapped, older adults, etc.
Unemployment Compensation
Workmen's Compensation

FAMILY PROBLEMS – See "Counseling"

FINANCIAL AID
Bail Program of Dauphin Co. . . . 238-4[illegible]2
Board of Assistance Welfare. . . . 787-[illegible]
(Food Stamps)
Budget Counseling. 392-2175
Medicare – See Social Security
Medicaid – See Board of Assistance
Social Security Office. 782-3400

FOOD SERVICES – Non-Emergency
Congregate Meals, Meals-on-Wheels
Food Stamps – See "Financial Aid"

FURNITURE – CLOTHING
Volunteers of America 238-9643

HANDICAPPED SERVICES
See "Health" by problem

HEALTH SERVICES
Centers
Medical Bureau 234-0165
Physician and Dental Referral
Children's Diagnostic Center 782-3365
Hamilton Health Center 232-9971
State Health Centers
Dauphin Co. 787-8842
Cumberland Co. 243-5151
State Health Line 1-800-692-7254
TEL-MED See pages ___ & ___ . . . 238-5100
Also, for information on borrowing free medical equipment, call CONTACT
Donors
Blood Bank of Central Pa. . . . . 534-[illegible]00
CLC Blood Bank . . . . . 564-[illegible]
Hershey Medical Center's
Humanity Gifts Registry. . . . . 534-8[illegible]

+ NOTE: Description of services for some agencies is very valuable, if space permits.

HEALTH ASSOCIATIONS by problem
- ...ritis Foundation 234-2661
- Asthma (childhood) Cystic Fibrosis Chapter 234-6852
- (adults) Xmas Seals 234-5991
- ...l Defects & High risk pregnancies March of Dimes. 545-4534
- Blind & Visually Handicapped
  - Tri-Co. Assn. of the 238-2531
  - Pa. Bureau of the. 787-7500
- Blood Pressure
  - American Heart Assn.. 564-7748
- Bronchitis
  - Cystic Fibrosis 234-6852
  - TB & Health Society 234-5991
- Cancer
  - American Cancer Society 545-4215
  - Penna. Cancer Hotline . . . 800-822-3963
- Cerebral Palsy Center 737-3477
- Cystic Fibrosis Chapter. 234-6852
- Diabetes Foundation 236-8164
- Deaf Ministry-Zion Lutheran. . . 233-0776
  - Polyclinic Hearing Center 782-4350
  - Teletypewriter Service — See "Handicapped" below
- Emphysema (childhood) — See Cystic Fibrosis Chapter . . . 234-6852
  - (adult) TB & Health. 234-5991
- Epilepsy Society 717-561-0107
- Handicapped
  - Easter Seal Society 564-6500
  - ... Bureau of ...oc. Rehabilitation 787-7834
  - ...eletypewriter 787-4013
  - ...rection Services I & R TTY & voice. 236-1133
  - CONNECT I & R. 800-692-7288
- Heart
  - American Heart Assn.. 564-7748
- Hemophilia Treatment Center
  - Hershey Medical Center 534-8399
  - (evenings-weekends). 534-8521
- Huntingdon's Disease
  - Central Pa. Chapter 238-4053
- Kidney Foundation 236-4470
  - Patient & Community Services
- Laryngectomies
  - New Voices Capital area Call Contact for Number. 652-4400
- Leukemia Aid Society 652-6459
- Lung & Health Service Assn. . . . 234-5991
- Multiple Sclerosis Society 652-2108
- Ostomy Assn. of Hbg. 766-5125
- Paraplegic Foundation 367-1161
  - Keystone Chapter 367-1161
- Speech Problems
  - Tri-Co. Easter Seal Society . . . 564-6500
  - Polyclinic Speech Center. 782-4350
- Sickle Cell Anemia
  - Hamilton Health Center 232-9971
- Surgery non-emergency
  - Nat'l. 2nd Opinion. 800-638-6833
  - ...lotline Information & Referral ...l Toll-Free 800-227-8922

HOME HEALTH CARE SERVICES
- Hamilton Home Health Agency . 232-9971
- Homemaker Services 233-6479
- Professional Home Health Care . 761-2181
- Visiting Nurse Assn., Hbg.. 233-1035

See Also "Home Health Services" in the Yellow Pages

HOUSING —Emergency Shelter
- Bethesda Mission. 232-0525
- YWCA, Harrisburg Area 234-7931

Temporary Housing
- Bethesda Mission. 232-0525
- YMCA, Harrisburg Area 234-6221
- YWCA, Harrisburg Area 234-7931

Housing Information
- Harrisburg Fair Housing Council (Tenant Complaints). . 233-3072
- Harrisburg Housing Authority . . 232-6781

HOSPITALS

Note: Listing your area hospitals here is highly recommended. Zip codes may be inserted for mailing convenience to friends of patients.

INFORMATION & LISTENING SERVICES
- Aging, Office of the. 299-7979
- Lanc. Info. Ctr.. 299-2821
- Military Info. Ctr. 392-8115
- Women's Ctr. 299-5381

LANGUAGE — INTERPRETERS

Asian:	Vietnamese:
Korean:	Laotian:
Spanish:	Medical Emerg.:

LEGAL SERVICES
- Lawyer Referral Services. 238-6715
- Legal services for low income 232-0581
- Public Defender for low income 299-8131

MARRIAGE PROBLEMS
See "Counseling"

PERSONAL PROBLEMS
See "Counseling"

MENTAL HEALTH

"Mental Health" covers wide range of emotional and personal problems. *List here all MH/MR programs in area.*

MENTAL RETARDATION
- Assn. for Retarded Citizens 234-7013
- Children's Care Center 566-3267
- Dauphin Residences (live-in) . . . 232-2002

See "Mental Health" above for all Centers

NURSING HOMES See yellow pages or County or State Agency on Aging

PRISON PROBATION
- Dauphin Co. Bail Program. 238-4602
- Probation & Parole Dauphin Co. Courthouse. 234-7001
- Volunteers of America (Half-way house for parolees) 236-1429

RECREATION-SOCIAL

Children-Youth-Adults
- Aurora Club 232-6675
- Bicycle Club of Hbg. 533-7100
- Boy Scouts. 238-9621
- Girl Scouts. 233-1656
- Boy's Club 234-3268
- Girl's Club 232-4898
- Hiking Clubs Call Your Recreation Bureau
- Jewish Community Center 236-9555
- Salvation Army Comm. Center. . 233-6755
- Social Groups, Call CONTACT. . 652-4400
- YMCA. 234-6221
- YWCA. 234-7931

Older Adults

Camps-programs-trips-Centers
- AARP . . . . . Local Number
- Area Agency on Aging 255-2877
- Boyd Center. 238-4718
- Jewish Community Center 236-9555
- Sr. Citizens' Office of Hbg. 255-6482
- Sr. Citizens' Service Centers Call 652-4400 for nearest one.

Or, call your local county, township, borough or city Recreation Department.

SENIOR CITIZENS

Note: Because of great need for help here, cross references are necessary.
- **Information & Referral** Area Agency on Aging 255-2877
- **Counseling** - Family & Children's Services 238-8118
- **Employment** — AARP. . . . Local Number or Green Thumb 123-4567
- **Foster Care** (private homes) Dauphin Co. Home 564-4580
- **Homemaker Services** 233-6479
- **Home Nursing Care** — See "Home Health Services"
- **Meals-on-wheels or Congregate meals** See "Food Services"
- **Nursing Homes** — See "Nursing Homes"
- **Personal Problems** — See "Counseling"
- **Tax help, rent rebates, etc.** . . . . . Call your Senior Citizens Service Center
- **Telephone Reassurance.** 255-6482
- **Volunteer** R.S.V.P. 232-1963

Note: Above alphabetically listed by service for easy reference.

NOTE: There are many hidden ideas in this prototype. You may wish to study it closely.

ELF-HELP SUPPORT GROUPS

Alcoholics Anonymous. 737-6242
Al-Anon/families. 737-6242
Cancer – Make Today Count. . *see below
Crib Death – Guild for Infant Survival . . . . . *see below
Divorce – Displaced Homemaker. 234-4004
Downs Syndrome – Parent Group 533-7667
Drug Abuse
Narcotics Anonymous . . . . . *see below
Nar-Anon/Families . . . . . *see below
Pills Anonymous. . . . . *see below
Gambling
Gamblers Anonymous . . . . . *see below
Gam-Anon/Families. . . . . *see below
Handicapped – Keystone Club . . . . . *see below
Kidney transplant & dialysis . . *see below
Mastectomy Patients
Reach for Recovery 236-5411
Nervous – Recovery, Inc. . . . . *see below
Overweight
Overeaters Anonymous. . . . . *see below
Parents
Drug Distress
Families Anonymous . . . . . *see below
Frustrated Abusers
Parents Anonymous. . . . . *see below

*Call CONTACT 652-4400 for number

SELF-HELP SUPPORT GROUPS—Cont'd.

Grieving
Compassionate Friends. . . . *see below
Parents without Partners. . . . *see below
Probation, Volunteers in. 234-5576
Smoker's Clinic. . . . . *see below
Widows Displaced Homemakers. 233-4004
Widows & Widowers
PROS . . . . . *see below

SEX-RELATED CONCERNS

Abortion
Nat'l. Abortion Hotline . . 800-223-0618
(Guidelines for clinic choice)
Birth Control - Counseling - Contraceptives
Family Planning or
Planned Parenthood. 234-2468
Course for expectant or new parents
Harrisburg Hospital 782-5701
Genetic Counseling
Hershey Medical Center 543-8106
Gay Counseling
Gay Switchboard. 234-0328
Lutheran Social Services. 626-1171
(Parent Counseling)
Pregnancy Counseling
Birthright (abortion alternates) 236-1661
Catholic Social Services 233-7978
Jewish Family Services. 233-1681
Lutheran Social Services. 626-1171

SEX-RELATED CONCERNS—Cont'd.

Prostitutes – Counseling
See Mental Health listings
Sexually Abused Children
Child Abuse Hotline. . . . 1-800-932-0313
Venereal Disease (VD) Call toll-free
VD Hotline 800-227-8922
Also see "HEALTH SERVICES" or yellow pages "Birth Control Information", or "Clinics".

TRANSPORTATION

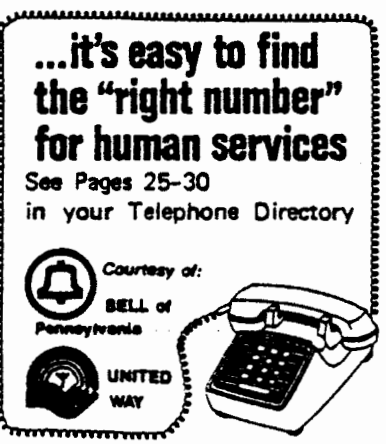
Area Agency on Aging 255-2877
Car Pool Program of Hbg. 234-3573
Community Action (low income) 285-3434
Emergencies Call CONTACT . . . 652-4400
Wheels, Inc. Tri-County 238-2321

VOLUNTEER PLACEMENT

Volunteer Service Center 299-2824

The Guide to Human Services was compiled by the United Way and is published in this Directory by Bell of Pennsylvania as a public service. For further information or improvement, call 123-4567 or write to (address).

United way



PUBLICITY

Until the public is aware of this service, it will not be fully used.

The response from newspaper editors, and television stations has been excellent. A blow-up of a section of the GUIDE will be useful as you send out news releases to all newspapers, including labor, school and church papers. Mass mailings of posters along with copies of the Guide, to Fire and Police departments, hospitals, doctors, businesses, motels and apartment managers . . . will be of great help in educating the public. Drop-in ads shown here may be used. *(Developed by the United Way of Pittsburgh).*

To help preserve and keep them updated, Lexington, Kentucky, provides a blue jacket with date and name in LARGE letters on the front. For sample, send $1 to "ASK US", 268 Short Street, Lexington, KY., 40507.

The new "BLUE PAGES" as now being used by AT&T and others, will soon diminish the need for publicity.

HELP!

Need help to solve your problems? See the new "Guide to Human Services" on Page 15 and 16 inside the cover of your telephone directory.

**For Directory Covers & Newspaper Fillers.*

To assist in further coordination of this effort, please send a copy of your own completed condensed listing of Human and Health service agencies, together with comments to Mrs. Hawthorn.

Note: For additional copies of this Prototype, send a self-addressed, stamped long envelope to:

Mrs. R. H. Hawthorn
PENNSYLVANIA DEPARTMENT OF HEALTH
Division of Health Education
P. O. Box 90
Harrisburg, PA 17120

POINTS TO CONSIDER . . .

In compiling

"GUIDE to HUMAN SERVICES"

By Millie Hawthorn, Consumer Consultant
Harrisburg, Pennsylvania

REVISED 1980

Assistance Provided by Pennsylvania Department of Health – Division of Health Education, and Graphics Section

This is an effort to assist you in compiling a condensed listing, by problem or service, of all direct-help human and health agencies within your community.

Most likely someone has already published a Directory of Services for your city. If so, you begin there. If not, you will probably get help from your local United Way or Council for Community Action. Other excellent groups to approach are Information and Referral people, Volunteer Bureaus, Mental Health, Area Agencies on Aging or even your library. When community leaders are made aware of what you are doing, you should have no trouble finding someone to coordinate the effort. More detailed help is available in the attached "how-to" pamphlet.

Following are important features to consider when compiling **your Guide:**

1. The ADVISORY COMMITTEE selected should include knowledgeable, responsible people within the community, and be kept small enough to be a good working group. Be sure to include a lay person to help keep it meaningful to the average citizen. The Guide will be used by many professionals, but it **is designed to be helpful to all people including children and older persons.**
2. State at the beginning that it is not an all-inclusive listing. Also, that non-profit and direct-service agencies only are listed. IMPORTANT . . . be sure to list the **community reference service number** at the top. Permission has been granted by the Information & Volunteer Services of Pittsburgh, Pa. to use the telephone symbol as shown in the prototype.
3. HEADINGS: The attached prototype covers many headings so that communities can choose those most applicable to their area. Ideally, the format and **headings should be somewhat standardized so it will be familiar to persons all over the country.**

   In many areas, Bell Telephone is providing pages for Government and other Public Services *(Easy Reference List)*, for tax offices, licenses, consumer needs, etc. The GUIDE to HUMAN SERVICES lists only the human or social services, which will include only a few government numbers that provide human help.
4. TYPE: Since many readers will have poor eyesight, **type chosen should be large and readable.** Larger cities may have to add additional pages, as is done in Pittsburgh and Philadelphia. Some communities like to set up their own type locally and make a trial distribution through banks, etc. This enables them to work out any deficiencies before submitting it to the telephone company.
5. SIMPLIFY! Guides that are easiest to read are those that **include only the most descriptive parts of the agency's names.**

   CROSS REFERENCES: Use these often to assist in finding help fast, i.e., DEAF, see "Health", or AGING, see "Senior Citizens", etc.
6. DATE THE PAGES. Experience is showing us that these pages will be reproduced and posted in hospital emergency and doctors' waiting rooms, police stations, etc. **If the date is not there or too small, they will not be replaced next year.**
7. DISCLAIMER: Be sure to include a small block at the end identifying the coordinating group or agency, with telephone number and address. This will take the agency selection and editing responsibilities from the telephone company, as it should. Including your address should encourage letters of suggested improvements for your Guide
8. Appoint a PUBLICITY COMMITTEE. **This is an excellent public relations tool** for the sponsoring groups and should be highly publicized. United Way may wish to identify their agencies with an asterisk (as shown on heading). Businesses are willing to cooperate when approached to assist as a public service.
9. Experience with the telephone companies has been very good. When it is time to update the pages for next year the only responsibility of the telephone company is to inform the Committee of the deadline for the next directory. **Final verifications of the numbers should be assumed by the telephone company.**
10. The prototype which follows is the result of many years of study and consultation with people, agency directors, and telephone company personnel. It is also an amalgam of many of the Guides that have already been published. This is a personal effort and does not necessarily reflect the thinking of any particular supportive group.

* *NOTE: Italics used in prototype are for instructions only.*

REVIEW

It is the author's vision to someday see Human, Health and Social Services coordinated and listed in a blue or green section of all directories as a public service. The cooperation of telephone companies has been excellent.

The present system of listing agencies in the yellow pages alphabetically makes it virtually impossible for one to find help easily. Also, many agencies without guidance in choice of headings, are not receiving their free listings or are lost to the public's view.

With easier accessibility to Human Services right within the telephone book, many calls can now be made directly to such places as Alcoholic Treatment Centers, or perhaps a counseling agency of their choice – thus saving untold hours of line and operator time. Even an I & R (Information and Referral) or "911" does not allow the freedom of choice, anonymity, and the time-saving element that this permits the user.

Telephone operators and supervisors now use the Guides regularly for those cities now providing it. The responsibility of supplying them with updated copies will presently fall on you until a normal system of delivery is established.

* * *

A new effort is underway with the United Way of Pennsylvania and Bell of Pennsylvania to further assist the "directory assistance operators" by providing them with a Directory of INFORMATION AND REFERRAL numbers by county in each area code. This will mean that persons who do not yet have the Human Services Guide in their directories, will be given their nearest I & R telephone number to obtain help when needed. For more information on this, you may contact Hal DeRolph at the United Way of Pennsylvania 717–238–7365.

* * *

Special thanks to Jim Long of Banks, Oregon, for his extensive research and untiring efforts as we worked together toward the green or blue pages concept.

Mrs. R. H. Hawthorn
Consumer Consultant Volunteer

* * *

Division of Health Education
PENNSYLVANIA DEPARTMENT OF HEALTH
P. O. Box 90
Harrisburg, PA 17120

A GUIDE FOR COMPILING A community human service guide

Revised 1980

PREFACE

In undertaking to publish my first Guide, a great deal of research and preparatory work was necessary before arriving at the final draft. Nearly every community has many public service agencies, organizations and self-help groups not generally known to the consumer; and the desire to make these more accessible to the public brought about the idea for the first Community HUMAN SERVICE GUIDE back in 1973.

It was originally a single sheet of condensed listings (by problem) designed for posting near or keeping in the telephone book. The single sheet concept is still retained in this revised "How-to" booklet, for those communities that may have to distribute it themselves with no present opportunity to include it in the telephone directory.

Other communities may like to produce and circulate their first Guide, before approaching their telephone company – since the discipline of arranging non-duplicating entries (and finding out what important services may have been missed) should be learned by the sponsoring group which is responsible for the final printing in the telephone directory.

Note: Much of the material in this pamphlet was written for the lay person, like a librarian, housewife or other volunteer – who often has more time to devote to such an effort in the beginning. By using suggestions outlined on the attached Prototype, a rough draft might first be made on the typewriter. Then, with the help of a sympathetic typesetter, a second then final draft might be made. Even in larger cities where the project may be undertaken by professional coordinators, having the type set up under their supervision will help the committee see the finished product before releasing it to the telephone company.

Step 1

Sponsor: First find a responsible sponsor such as your local United Way, Council of Churches or Chamber of Commerce. You will need their support in exchange for the good public relations this will provide them. If it can be done in their office, using their stationery, all the better. If done in a home by an individual, use your sponsor's stationery with your own name and return address, typing "volunteer" under it.

Next, find a community-minded business that is centrally located (with easy parking) who will underwrite the printing costs, in return for the good will that is generated by their willingness to give out free single copies or larger quantities to Welcome Wagon, Chamber of Commerce distribution, or County Medical Society mailings to doctors and dentists.

Step 2

The File Box: Begin with a categorical card file so each agency will be filed alphabetically by problem or service heading. Type the name that is actually used in the Guide (avoid listing the area).... followed by their telephone number. For example: Cancer Society, not American Cancer Society.

Be sure to catalog their complete and proper name and address for use when later mailing copies to them. Follow this with the name of the director and the date (in case of change). On this card you will gather other pertinent information such as telephone hours, number of persons on the staff, etc.

Step 3.

Selection of Agencies: Avoid agencies that do not give direct help to people. If a CONSUMER ACTION GROUP does this, list them under the proper heading. Many such groups are there to assist agencies only.

Be as certain as possible that it is not a temporary agency, however well-meaning. Also, to be eligible they must be non-profit and offer their services free to those unable to pay. Try to keep within your toll-free area.

Home telephone numbers of individuals who conduct their service from their homes should be avoided. Usually there is an I & R (Information and Referral) group in your area that will permit you to use their number. See SELF-HELP groups on attached Prototype. Important: They should be advised to keep the I & R director informed of any changes.

Step 4

Contacting the directors: If the community is not too large, you can telephone the directors personally, identifying yourself as a volunteer for the sponsoring agency. Explain the reason for the call and tell them you will try to include them in this new effort. Space will permit only the most useful and active agencies. Advise them that since space is limited, their name may have to be condensed.

Ask for a complete list of their services and record it on the file card. Explain that space may permit a condensed description of services — possibly one line. After you have worked with it, be sure to finalize your copy with the director before going to press. In most cases, listing under the proper heading may be sufficient.

In larger cities, mailing out a survey sheet to the directors may be necessary, asking them to return it by a certain date, listing their first, second, and third category choices for their listing. Personal experience, however, has shown this to be not always satisfactory — since most directors are busy people and too often they are done hurriedly or not at all. The personal touch by telephone is excellent. This will also give you an opportunity to gather other pertinent information, such as their telephone hours, the number of persons on the staff, etc. Also, to explain why you may have to limit their listing to one category.

Step 5

When to talk to an Administrator: Where there are several agencies under one group, such as the MENTAL HEALTH group, it is wise to clear your final copy with the overall administrator. This can also be of great help to you in clarifying the role that each separate center plays and just how to list them in your Guide.

Step 6

It is best to work on one segment at a time. For example: SURVIVAL BLOCK, COUNSELING, HEALTH SERVICES, etc., and for the sake of the printer, label each segment A, B, C, etc., submitting each segment on a separate page.

Step 7

Where to find the agencies: It may take a great deal of effort to find and identify all the agencies and organizations in your area and to catalog the kind of services they render. It is important that you inquire closely into each one that you are considering, so that you do not inadvertently include some that are profit making services.

Your local United Way office or Area Agency on Aging will have many agencies already listed. From there you can find others in the yellow pages of your telephone book under "Human or Social Services", or listings under many other headings. If you have a local I & R Center, such as CONTACT or a HELP LINE, they may already have all that you would need for your condensed listing. In other areas those same people may be looking for such a list to post beside their telephone for quick reference (and to add to their own lists.) Watch newspapers carefully.

Step 8

Typesetting: For an area of 10,000 homes within this telephone area (not long distance) we found the agencies just filled an 8½ x 11 sheet, using the smallest legible print available. . . News Gothic condensed. If your area is smaller, you may find it possible to use larger type. If larger, it would be necessary to use an 8½ x 14 sheet, but avoid this if possible because of the cost. Once you have typed up your first draft, you can then decide on the size type permitted by going to your local typesetter or a friendly weekly Shopping Guide who may assist you in setting up the Guide. Since you may be working with little or no money, every effort should be made to find a printer who understands the need for this public service and will print it for you at his actual cost. Some areas are now using the United Fund to underwrite the printing costs.

It is preferable to get permission to work directly with their typesetter. This is mentioned now because you will have to know exactly to the letter, how much space is permitted when typing your second draft. Ask for sample of one segment (like Crisis Intervention or Suicide Prevention) in several sizes of type so you can figure how many spaces on your typewriter is equivalent to the actual type you chose. This also applies to the number of lines that will be allowed. Try to be consistent in your indentations and abbreviations.

Subheading should all be bold face. Important: In order to adhere to the AT&T standards for the benefit of persons with poor eyesight, type similar to that used in the Prototype is recommended. When typing copy count strokes to exactly equal print that will be used (approximately 39). This will avoid costly makeovers by printer.

Step 9

Printing: White 60 pound offset is the ideal paper, particularly if you want to print on both sides. We have been fortunate in obtaining cost quotes, printed on both sides and folded when requested. At this price it is easier to interest churches and township or borough tax offices to help in the distribution. Vo-tech schools might print them, being sure that the original is set up by a professional typesetter. Large quantities can be ordered directly from the printer at cost and either picked up or delivered to the sponsoring bank, church, etc., and billed directly to them. In such cases, be sure to ask them to print on the bottom of the sheet: "Distributed through courtesy of _____". Banks, Savings and Loan or other institutions (through approval of their Boards or community service directors) are good prospects. They will want to use their logo.

Step 10

Distribution: Before having a large quantity of the Guide printed, the final test (to see if you missed any eligible agency) is to ask your local newspaper to print it as a public service. Be sure to include your name and telephone number at the bottom. Even after a double check on each telephone number, you still may receive a call asking for a correction. Then only should you feel free to print up several thousand copies, being sure to send several to each of the agencies. Our local RSVP volunteers were invaluable in helping to address the above envelopes and also stuffing in tax mailings.

When your Council of Churches includes it with a mailing to all the ministers, be sure to suggest or help them staple a note to each one suggesting that they "may wish to ask the church secretary to order enough copies to include in a piggyback mailing to their congregation". Following are many sources for distribution that are usually happy to cooperate:

Banks — Piggyback mailings to customers with their own logo printed in one corner. They will pay printing costs.

Earned Income Tax or County Tax mailings through Area or County tax bureaus.

Hospitals — Social Service Directors.

County Medical Association — Several copies to every doctor.

County Bar Association — Several copies to each lawyer.

Schools — Superintendents will welcome a copy and will usually order enough for every teacher, counselor, nurse and office for posting. Also, for distribution with the annual school calender.

Chamber of Commerce — Mailings to membership.

Apartment House Managers — They like one to give each tenant.

Motel and Hotel owners — These, like above, might be covered through telephone calls by your committee using the yellow pages, and counted and dispensed through your RSVP volunteers.

Welcome Wagon — Your sponsoring business should be willing to contribute these.

Police Stations — Mayor's office — township and borough government offices.

Step 11

Posting: Here is where a dedicated committee is needed! Each one should carry a small quantity in their car, together with Scotch Magic tape for posting in Shopping Malls, Donut Shops, Bars, grocery stores or near any public telephone. Important: Be sure to ask permission from the Mall Managers, and owners before posting them. Important! A distribution committee should be formed with each person being responsible for his or her section of the area. Posted Guides must be replaced with new, revised, copies. Best results are with the use of 8½" x 11" plastic pages and double tacking tape. Postmasters will post them in each of their post offices.

Step 12

The organization devoted to HEALTH may take days of research to gather, but it is particularly valuable to physicians to post in their examining rooms to assist doctors in guiding patients to the proper organizations for their particular disability.

The most valuable contribution this Guide can make, however, is to assist all doctors in encouraging their patients to make an immediate appointment with a Mental Health Center or other Counseling Center, or alcoholic or drug victims to make that call while in the doctor's office. Too often busy doctors cannot take the time to help the patient find the additional help needed.

* * *

Note: One of the new features in this prototype is the alphabetical listing by problem under SENIOR CITIZENS, SELF-HELP GROUPS, SEX-RELATED CONCERNS, as well as HEALTH ASSOCIATIONS. This makes it easier for the consumer to find help faster.

* * *

A word about **Mental Health listings.** You will notice that an effort has been made to keep the word "retardation" out of this group, in order to encourage calls from emotionally disturbed persons.

Also, space can be saved by listing the MH—MR Centers just once, then using a cross reference.

* * *

In the SURVIVAL BLOCK, please note that you can call a toll-free number for Parents Anonymous to help locate your nearest state office or local group. Call 800—421—0353.

Allen D. Edwards, President
Catawba Chapter, AARP
1177 Mary Dale Lane
Rock Hill, SC 29730

Dr. Edwards expressed his appreciation to the Committee for helping to get the new insurance regulations regarding "Medigap Insurance" passed.

Senator Rubin said that Mrs. Bumgardner is to be credited for getting this done. He commented that the new regulations should provide protection for the elderly in insurance matters.

The Catawba Chapter supports the legislative objectives of the Joint State Legislative Committee, NRTA-AARP, and the following matters are of special concern to the Chapter members:

1. Revision of the S. C. Probate Code.
2. Housing needs. A serious problem is created by the conversion of apartments into condominiums especially for low and middle-income families. Also, protection against sudden and too high increases in rent should be considered.
3. Long term care facilities can not take care of present demand.
4. Increases in home care services. All such services available to low income families should be available to families who are able to pay. This would greatly contribute to avoid institutionalization.
5. Transportation. Better management of public transportation companies, better coordination of agency vehicles, special reductions to senior citizens during non-peak hours are just a few of the suggestions made.
6. Restitution to crime victims in cases of vandalism or attacks that require medical treatment.

In addition, Dr. Edwards listed the following concerns:

a). Continue cost-of-living increases
b). Adopt minimum standards for conversion of rental units into condominiums
c). Expand home maker services to prevent institutionalization of elderly
d). Support the passage of the Natural Death Act

Senator Rubin thanked Dr. Edwards for his very thoughtful suggestions.

Catawba Chapter

of the AMERICAN ASSOCIATION OF RETIRED PERSONS, Inc.

Statement at Public Hearing of Joint Study Committee on September 12, 1980

Senator Rubin, Members of the Study Committee on Aging, Ladies and Gentlemen:

The Catawba Chapter of the American Association of Retired Persons of Rock Hill, S. C. wishes to express appreciation to this committee for the interest they have shown in the needs of the elderly in South Carolina and for their many accomplishments in this area.

The Chapter fully supports the legislative objectives of the Joint State Legislative Committee, NRTA-AARP. The following matters are of special concern to our members:

1. Revision of the South Carolina Probate Code. The S. C. Bar Committee studying the probate code has prepared a proposal which has been approved by the S. C. Bar. This proposal is now being considered by a joint committee of the Legislature. We hope that legislation can be enacted in 1981 that will be of benefit to all citizens of the State.
2. Housing needs. Drastic increases in taxes for homeowners, great increases in rent for some renters (particularly those whose dwellings have been sold), and eviction of renters when apartments are converted into condominiums are a serious problem to many low and middle-income families. Some protection of renters against too great and sudden increases in rent should be considered. Renters in buildings being converted into condominiums should be given some protection. These problems are being compounded by drastic increases in the prices of fuel, electricity and food.
3. Long term care facilities are inadequate for present demand. We are told that there is a waiting period of five to six months for such facilities in Rock Hill.
4. Alternatives to institutionalization. We favor increases in services for home care. All such services available to low income families should be available to families able to pay for them.
5. Transportation continues to be a high-priority need for persons without access to private automobiles. Better management of public transportation companies, better coordination of agency vehicles, subsidized use of taxis, special reductions to senior citizens riding during non-peak hours, and encouragement of volunteers to transport their neighbors are among measures that might be considered.
6. Crime prevention. Restitution might be utilized more in the sentencing of offenders. Crime victims should be given restitution in cases of vandalism or attacks requiring medical treatment.

Allen D. Edwards, President
Catawba Chapter, AARP
1177 Mary Dale Lane
Rock Hill, S. C. 29730

SUBMITTED BY DR. ALLEN D. EDWARDS, PRESIDENT, CATAWBA CHAPTER, AARP
with Statement at Public Hearing of Study Committee on Aging, 9/12/80

Ann Landers

The right to die in peace

Styles in living

5-A Friday, June 6, 1980

DEAR ANN LANDERS: In the last eight months I have lost my father and sister to cancer. She was the beauty of the family and only 42 years old. It was lung cancer. She had been smoking since high school.

Dad had cancer of the colon. He was one of those hale and hearty types, never sick a day in his life. So why go to a doctor for a check-up? He died on his 66th birthday.

The reason I am writing is to ask if it is possible, should I get a terminal illness, to prevent the doctors from keeping me alive by artificial means? I saw my sister and dad linger for weeks when there was no chance for survival. It was obscene the way they kept Dad "alive" by using a kidney machine and a respirator — with tubes inserted in every orifice. Dad pleaded with us to instruct his physician to let him die in peace, but neither I nor my mother could bring ourselves to do it. We both feared guilt feelings might haunt us later, and of course, we were constantly praying for that one-in-a-million miracle.

Can a person make legal arrangements, in case of a terminal illness, to guarantee that he will not be kept alive on machines? Sign me — THANKS, BUT NO THANKS IN ILLINOIS

DEAR THANKS: Yes, you can have your way if you live in a state that recognizes the "living will." (Illinois is one that does.) This is a document, signed by you, which guarantees the right to die in peace should you be stricken with a terminal illness that your physician declares is irreversible. The living will relieves relatives and doctors of the responsibility of making the decision.

Anyone who wants more information and a free copy of a living will can obtain one by writing to Concern for Dying, 250 West 57th St., New York, N.Y. 10019. This organization has sent out more than three million copies. At this writing, only ten states have a "right to die" law. If you live in a state that has no such law, your family and doctor may not be willing to respect your wishes, but they will be aware of what your wishes are.

DEAR ANN LANDERS: Why would a man who has been married for six months to a woman he says he loves a lot mention his ex-wife's name in his sleep? He was married to this person for 14 years and claims it was a lousy marriage. This happened two weeks ago, and I haven't been able to get it off my mind.

I need an answer because it's driving me nuts. — NEW ENGLANDER IN DISTRESS

DEAR DIS: He probably was having a nightmare. Forget it.

Dr. Ernest Finney, Chairman
S. C. Commission on Aging
915 Main St.
Columbia, SC 29201

Senator Rubin extended his congratulations to Dr. Finney on his recent appointment to the Board of Trustees at Columbia College.

Dr. Finney's remarks addressed the following:

1. Inflation and the energy crisis.
2. Transportation problems continue to be the number one necessity for older South Carolinians. It is urgent that an adequate transportation system be developed.
3. County Councils on Aging need assistance against the mounting costs of gasoline; this problem is especially severe in the rural areas.
4. The Commission on Aging has been designated by Governor Riley to coordinate State activities for the upcoming White House Conference on Aging. A Governor's White House Conference will be held next May, at Columbia College. Five hundred delegates from around the State will consider a number of issues of vital importance to the aging. A State Report will then be drawn up, containing recommendations from that Conference, and will be forwarded to the National White House Conference on Aging, to be held in November of 1981.
(Prepared statement follows on the next pages).

REMARKS BY DR. ERNEST A. FINNEY, CHAIRMAN

SOUTH CAROLINA COMMISSION ON AGING

To

LEGISLATIVE STUDY COMMITTEE ON AGING

PUBLIC HEARING

SEPTEMBER 12, 1980

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

THE EFFORTS OF YOUR COMMITTEE HAVE GREATLY BENEFITED THE SENIOR CITIZENS OF SOUTH CAROLINA. THE COMMISSION ON AGING COMMENDS THOSE EFFORTS ON BEHALF OF ALL OLDER SOUTH CAROLINIANS AND THE COMMISSION ITSELF.

WITH THE CONTINUED COMMITMENT OF YOUR COMMITTEE, AS WELL AS THE MEMBERS OF THE LEGISLATURE, CHALLENGES TO THE WELL-BEING AND DIGNITY OF OUR SENIOR CITIZENS CAN BE MET HEAD-ON, AND OVERCOME.

ALL OF US SUFFER FROM INFLATION AND THE ENERGY CRISIS. HOWEVER, THE OLDER POPULATION'S CONDITION IS INTENSIFIED BECAUSE OF FIXED INCOMES AND THE MULTIPLE PROBLEMS OF OLD AGE. THE BURDEN OF INFLATION ON MANY SENIOR CITIZENS CONTINUES TO DEVASTATE ~~DEVASTE~~ THEIR ABILITY TO MEET THEIR BASIC AND ESSENTIAL NEEDS.

THE COMMISSION, THROUGH AREA AGENCIES ON AGING AND LOCAL COUNCILS ON AGING, HAS BEEN ABLE TO PROVIDE FOR A WIDE VARIETY OF SERVICES TO ASSIST SENIOR CITIZENS, BUT THIS IS OF LITTLE HELP TO THE PERSON WHO CANNOT GET TO THESE SERVICES. TRANSPORTATION CONTINUES TO BE THE NUMBER ONE NECESSITY FOR OLDER SOUTH CAROLINIANS. WE MUST ADDRESS OURSELVES TO THE DEVELOPMENT OF A TRANSPORTATION SYSTEM THAT WILL PROVIDE ADEQUATE AND TIMELY SERVICE TO SENIOR CITIZENS, UTILIZING THE BEST OF EXISTING TRANSPORTATION SYSTEMS, BUT INCLUDING PORTAL-TO-PORTAL SERVICE FOR THE FRAIL ELDERLY WHO CANNOT WALK TO THE BUS STOP.

THE COUNTY COUNCILS ON AGING, WHICH PROVIDE MOST OF THE COMMUNITY BASED SERVICES TO THE ELDERLY, ARE IN DIRE NEED OF ASSISTANCE AGAINST THE MOUNTING COST

OF GASOLINE. THE PROBLEM IS MORE INTENSE IN THE RURAL AREAS.

THE UPCOMING WHITE HOUSE CONFERENCE ON AGING IS OF VITAL IMPORTANCE TO ALL OLDER AMERICANS. THE COMMISSION ON AGING IS PLEASED TO HAVE BEEN DESIGNATED BY GOVERNOR RILEY TO COORDINATE STATE ACTIVITIES FOR THIS CONFERENCE, AND THE IMPORTANCE OF IT TO AGING INTERESTS CANNOT BE OVERSTATED. ONCE EVERY TEN YEARS AGING ISSUES GAIN NATIONAL ATTENTION UNDER THE AEGIS OF THE WHITE HOUSE. SOUTH CAROLINIANS NOW HAVE THE OPPORTUNITY TO MAKE RECOMMENDATIONS AND EXPRESS THEIR CONCERNS ON AGING THROUGH THE PROJECTED FIVE HUNDRED (500) LOCAL COMMUNITY FORUMS THAT ARE BEING HELD THROUGHOUT THE STATE THROUGH OCTOBER.

PLANS ARE UNDERWAY FOR THE GOVERNOR'S SOUTH CAROLINA WHITE HOUSE CONFERENCE THAT WILL BE HELD NEXT MAY, AT COLUMBIA COLLEGE. MEMBERS OF THIS COMMITTEE WILL RECEIVE INVITATIONS TO ATTEND THIS IMPORTANT EVENT. WE HOPE ALL OF YOU WILL PARTICIPATE. FIVE HUNDRED (500) DELEGATES FROM AROUND THE STATE WILL CONSIDER A NUMBER OF ISSUES CRUCIAL TO THE AGING. RECOMMENDATIONS FROM THE CONFERENCE WILL THEN BE INCLUDED IN THE STATE REPORT WHICH WILL BE FORWARDED TO THE NATIONAL WHITE HOUSE CONFERENCE ON AGING, TO BE HELD IN LATE NOVEMBER 1981. THE RESULTS OF THE 1981 WHITE HOUSE CONFERENCE ON AGING WILL HAVE FAR-REACHING IMPLICATIONS FOR NATIONAL AGING POLICY AND PROGRAM INITIATIVES. WE RESPECTFULLY URGE YOU TO PARTICIPATE IN WHITE HOUSE CONFERENCE ON AGING ACTIVITIES IN OUR STATE TO HELP MAKE OUR RECOMMENDATIONS RESPONSIBLE AND SIGNIFICANT.

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE, THE ANNOUNCEMENTS FROM THE BUDGET AND CONTROL BOARD THIS WEEK ARE GIVING US A GREAT DEAL OF CONSTERNATION. MR. BRYAN WILL ADDRESS THIS MATTER AND GIVE YOU OTHER SUGGESTIONS FOR LEGISLATIVE ACTION AT THIS TIME.

Harry R. Bryan, Director
Commission on Aging
915 Main St.
Columbia, SC 29201

Senator Rubin mentioned that he wanted to take note at this time that some statements had been mailed in for the Committee's action. They will be filed in the back of the transcript.

He also welcomed Mrs. Sarah Shuptrine who had just joined the Hearing.

Mr. Bryan voiced concern over the recommended cut in State funds for personnel and administration as the Budget and Control Board had announced earlier and will be effective for the next fiscal year. Their Federal funds for administration are capped at $300,000 and in order to maintain their current level of operation they need an increase of more than $90,000.

He presented the following legislative proposals:

1. South Carolina Probate Code. He asked the Committee's continued interest and support for this much-needed legislation.
2. Medigap Insurance Regulation. Problems that have been associated with the purchase of health insurance to supplement Medicare coverage have been arrested. However, in order to meet Federal legislation standards, South Carolina needs to set a Loss Ratio for Medigap policies. The Commission on Aging urges the Committee to amend the Regulation implementing the Minimum Standards Act to include a Loss Ratio requirement.
3. Homestead Exemption for Renters. While the recent amendments to the Homestead Tax Exemption legislation have greatly relieved the tax burden for senior citizens, the Commission would like to see similar benefits for elderly renters.
4. Transportation Needs. Increasing gasoline and insurance costs, make it more difficult to recruit and keep volunteers who drive their own cars to deliver meals or take sick older persons to medical appointments. It would be helpful if local service providers could get gasoline and vehicles at lower costs. He

referred to a letter from Mrs. Brittie C. Bellamy, Executive Director, Horry County Council on Aging. (This statement was mailed in and is attached to the back of the transcript, page 157).

5. Community Services for the Frail Elderly. The Commission strongly supports in-home and other needed community health and social services. They are actively involved in the two model projects which stress availability of these services and urge the Committee to be prepared to support legislation expanding such services statewide. Mr. Bryan added that they may present a recommendation in the future for legislation to enact a "Community Services for the Elderly Act."
6. Condominium Conversion. Other states have passed legislation in this area; such as, allowing elderly tenants who have lived in an apartment for a certain number of years to remain as a tenant or giving the elderly tenant first option to buy. The Commission on Aging proposed to study various options and report back to the Committee with a recommendation.

Other items he mentioned for the Committee's consideration were:

1. Further study of ways to improve the S. C. Medicaid Program.
2. Find ways to lower the burden of high energy costs for low-income persons living on fixed income.
3. Make voting places accessible to the handicapped.
4. Enactment of an "Age Discrimination Act" in South Carolina. The Commission will study this and report back to Committee.
5. Curtailment of rising health care costs.
6. A "Senior Discount Bill" to promote discount programs for retirees all over the State.

Senator Rubin thanked Mr. Bryan for his presentation telling him that the Committee is looking forward to hearing further from him on some of the legislation which he has recommended and which apparently is coming of time.

REMARKS BY HARRY R. BRYAN, DIRECTOR
SOUTH CAROLINA COMMISSION ON AGING

TO

LEGISLATIVE STUDY COMMITTEE ON AGING
PUBLIC HEARING
SEPTEMBER 12, 1980

I CERTAINLY CONCUR WITH DR. FINNEY, ON BEHALF OF ALL SENIOR SOUTH CAROLINIANS AND THE COMMISSION ON AGING, ON THE OUTSTANDING WORK OF THIS COMMITTEE. WE ARE, INDEED, MOST GRATEFUL.

WE ARE EXTREMELY CONCERNED ABOUT THE RECOMMENDED CUT IN STATE FUNDS FOR PERSONNEL AND ADMINISTRATION ANNOUNCED BY THE BUDGET AND CONTROL BOARD EARLIER THIS WEEK, FOR THE NEXT FISCAL YEAR. OUR FEDERAL FUNDS FOR ADMINISTRATION ARE CAPPED AT $300,000. IN ORDER TO MAINTAIN OUR CURRENT LEVEL OF OPERATION--OUR CURRENT LEVEL OF EFFECTIVENESS--WE NEED AN INCREASE OF MORE THAN $90,000. THE DECREASE IN STATE FUNDING PROJECTED FOR US WILL BE DEVASTATING. IF IT IS SUSTAINED, IT WILL REQUIRE A TEN PERCENT (10%) REDUCTION IN PERSONNEL--THREE STAFF MEMBERS. WE HAVE ONLY 31 NOW. OUR ABILITY TO CARRY OUT OUR MANDATED STATEWIDE RESPONSIBILITIES--OUR CAPACITY TO DO OUR JOB PROPERLY--WILL BE GREATLY CURTAILED.

NEVERTHELESS, IF THE CUT HAS TO BE MADE, WE'LL CONTINUE TO DO OUR VERY BEST FOR ALL OLDER SOUTH CAROLINIANS. WE HAVE FAITH, HOWEVER, AND WE ARE CONFIDENT THAT THE GENERAL ASSEMBLY WILL DILIGENTLY AND SUCCESSFULLY SEEK A SOLUTION TO THIS PROBLEM.

I WOULD LIKE, AT THIS TIME, TO PRESENT SOME LEGISLATIVE SUGGESTIONS FOR YOUR CONSIDERATION:

SOUTH CAROLINA PROBATE CODE: ADOPTION OF THE UNIFORM PROBATE CODE WOULD SIMPLIFY THE PROCEDURES FOR SETTLEMENT OF ESTATES, A TASK THAT FREQUENTLY INVOLVES OLDER CITIZENS. AS YOU KNOW, A SPECIAL STUDY COMMITTEE HAS BEEN MEETING THIS SUMMER TO REVIEW A DRAFT OF THE PROPOSED S.C. PROBATE CODE SUBMITTED BY THE SOUTH CAROLINA BAR ASSOCIATION. THIS HAS BEEN A SLOW PROCESS. UNTIL IT IS APPROVED AND ADOPTED, THE COMMISSION URGES YOUR CONTINUED INTEREST AND SUPPORT FOR THIS MUCH-NEEDED LEGISLATION.

MEDIGAP INSURANCE REGULATION: THE PROBLEMS THAT HAVE BEEN ASSOCIATED WITH THE PURCHASE OF HEALTH INSURANCE TO SUPPLEMENT MEDICARE COVERAGE HAVE BEEN ARRESTED WITH THE ADOPTION OF REGULATIONS GOVERNING THE SALE AND SOLICITATION OF MEDIGAP INSURANCE. FEDERAL LEGISLATION HAS BEEN PASSED ON THIS ISSUE. STATES HAVING STANDARDS AT LEAST AS STRICT AS THOSE CONTAINED IN THE FEDERAL LEGISLATION CAN PREVENT FEDERAL REGULATION IN THIS AREA. SOUTH CAROLINA MEETS THIS REQUIREMENT EXCEPT FOR SETTING A LOSS RATIO FOR MEDIGAP POLICIES. THE COMMISSION ON AGING STRESSES THE NEED TO AMEND THE REGULATION IMPLEMENTING THE MINIMUM STANDARDS ACT TO INCLUDE A LOSS RATIO REQUIREMENT FOR MEDIGAP POLICIES, AND WE URGE THIS COMMITTEE TO PRESS FOR THIS AMENDMENT.

HOMESTEAD EXEMPTION FOR RENTERS: SOUTH CAROLINA'S HOMESTEAD TAX EXEMPTION FOR THE ELDERLY, WITH THE RECENT AMEND-

MENTS YOU HAVE SPEARHEADED, GOES A LONG WAY TOWARD PROVIDING THEM MUCH NEEDED TAX RELIEF. THE COMMISSION ON AGING WOULD LIKE TO SEE THIS COMMITTEE LOOK MORE THOROUGHLY INTO A SIMILAR BENEFIT FOR THE ELDERLY RENTER. POSSIBLY, A REAL PROPERTY TAX EXEMPTION TO THE LANDLORD OF ELDERLY TENANTS COULD BE PASSED ON TO THE LEASEE (THE ELDERLY TENANT) IN THE FORM OF A RENT REDUCTION, OR, PERHAPS IT WOULD BE BEST TO GIVE IT DIRECTLY TO THE ELDERLY RENTER IN THE FORM OF A TAX CREDIT.

GASOLINE AND VEHICLES: DR. FINNEY HAS EMPHASIZED THAT TRANSPORTATION CONTINUES TO BE A MAJOR NEED FOR OUR OLDER CITIZENS. THE COST OF GASOLINE AND VEHICLES PRESENTS AN ACUTE PROBLEM FOR COUNTY COUNCILS ON AGING AND OTHER LOCAL SERVICE PROVIDERS STRIVING TO TRANSPORT THE SOCIALLY AND ECONOMICALLY DEPRIVED ELDERLY SO THAT THEY CAN OBTAIN MUCH-NEEDED SERVICES THAT ARE AVAILABLE TO THEM. AS WAS BROUGHT OUT LAST YEAR, THE COST OF GASOLINE, AND INSURANCE, IS MAKING IT MUCH MORE DIFFICULT TO RECRUIT AND KEEP VOLUNTEERS WHO DRIVE THEIR OWN CARS TO DELIVER HOT MEALS TO ELDERLY SHUT-INS OR TO TAKE SICK OLDER PERSONS TO MEDICAL APPOINTMENTS. IT WOULD BE MOST HELPFUL IF A METHOD COULD BE DEVELOPED FOR PROVIDING GASOLINE--AND VEHICLES--TO THESE ORGANIZATIONS AT LOWER COSTS. (PLEASE REFER TO LETTER OF 7/28/80 FROM MRS. BRITTIE C. BELLAMY, EXECUTIVE DIRECTOR, HORRY COUNTY COUNCIL ON AGING.)

COMMUNITY SERVICES FOR THE FRAIL ELDERLY: THE COMMISSION STRONGLY SUPPORTS IN-HOME AND OTHER NEEDED COMMUNITY HEALTH AND SOCIAL SERVICES FOR THE VERY OLD, FRAIL, HEALTH-IMPAIRED, HIGHLY VULNERABLE ELDERLY. SOUTH CAROLINA'S TWO MODEL PRO-

JECTS STRESSING AVAILABILITY OF SUCH SERVICES AND ACCESSIBILITY TO THEM HAVE BEEN DISCUSSED WITH YOU BY OTHERS. THE COMMISSION ON AGING IS ACTIVELY INVOLVED WITH BOTH OF THESE AND IS STRONGLY COMMITTED TO THEM. WE ENCOURAGE YOU TO CONTINUE TO WATCH THESE PROJECTS AND TO BE PREPARED TO SUPPORT LEGISLATION EXPANDING SUCH SERVICES STATEWIDE. WE MAY PRESENT A RECOMMENDATION TO YOU NEXT YEAR, OR THE FOLLOWING YEAR, FOR LEGISLATION TO ENACT A "COMMUNITY SERVICES FOR THE ELDERLY ACT" IN SOUTH CAROLINA.

CONDOMINIUM CONVERSION: CONVERTING APARTMENT COMPLEXES INTO CONDOMINIUM PROJECTS HAS CREATED HOUSING PROBLEMS FOR THE ELDERLY ACROSS THE NATION. SENIOR CITIZENS WHO HAVE SOLD THEIR FAMILY HOMES TO LIVE IN A MORE MANAGEABLE ENVIRONMENT ARE FACED WITH THE CHOICE OF REINVESTING THE PROCEEDS OF THE PRIOR SALE INTO THE CONDOMINIUM PROJECT OR UNDERGOING THE TRAUMA OF ANOTHER MOVE. OTHER STATES HAVE PASSED LEGISLATION IN THIS AREA. TYPICALLY, THE STATUTES ALLOW THE ELDERLY TENANT WHO HAS LIVED IN THE APARTMENT FOR A CERTAIN NUMBER OF YEARS TO REMAIN ON AS A TENANT. OTHER STATES GIVE THE ELDERLY TENANT FIRST OPTION TO BUY. THE COMMISSION ON AGING SEES A NEED FOR SUCH LEGISLATION. WE PROPOSE TO STUDY THE MERITS OF THE VARIOUS OPTIONS AND REPORT BACK TO YOU WITH A RECOMMENDATION.

BRIEFLY, HERE ARE SOME OTHER ITEMS FOR YOUR CONSIDERATION:

-- FURTHER STUDY OF WAYS TO IMPROVE THE SOUTH CAROLINA MEDICAID PROGRAM SO THAT PHYSICIANS AND OTHER PROVIDERS WILL CONTINUE TO PARTICIPATE AND THE ELDERLY

WILL GET MAXIMUM POSSIBLE BENEFITS, INCLUDING THE ADOPTION OF A "SPENDDOWN" PROGRAM FOR THE MEDICALLY NEEDY.

-- FURTHER STUDY OF WAYS TO LOWER THE BURDEN OF HIGH ENERGY COSTS FOR LOW-INCOME OLDER PERSONS LIVING ON FIXED INCOMES.

-- LEGISLATION REQUIRING THAT ALL VOTING PLACES (POLLS) IN SOUTH CAROLINA BE LOCATED IN BUILDINGS ACCESSIBLE TO THE HANDICAPPED, MANY OF WHOM ARE ELDERLY.

-- CONSIDERATION OF THE NEED FOR AN "AGE DISCRIMINATION ACT" IN SOUTH CAROLINA. COMMISSION ON AGING STAFF WILL STUDY THIS AND REPORT FURTHER TO YOU ON IT.

-- EFFORTS TO CURTAIL THE RISING COSTS OF HEALTH CARE.

-- A "SENIOR DISCOUNT BILL", MODESTLY FUNDED, TO PROMOTE DISCOUNT PROGRAMS FOR RETIREES ALL OVER THE STATE.

WE APPRECIATE THE OPPORTUNITY TO PRESENT THESE SUGGESTIONS TO YOU AND AGAIN WE EXPRESS OUR THANKS TO THE ENTIRE COMMITTEE FOR A JOB WELL DONE ON BEHALF OF OLDER SOUTH CAROLINIANS.

Dr. Obert Kempson, Chairman
S. C. Commission on Aging Churches Committee
915 Main St.
Columbia, SC 29201

Each religious denomination in the State has been invited to have a representative on this Committee. Dr. Julian Parrish of the Study Committee on Aging is an active member. The Committee conducts workshops and prepares pamphlets for guidance of churches and temples.

The Committee expresses concerns in the following areas:

1. Churches and temples need to work with community agencies to find out where the aging are in a community and who cares about them.
2. Churches and temples need to exert efforts so that existing programs for older persons really meet their needs.
3. The aging should be engaged in determining their needs.
4. There is a greater need of advocacy for and with the elderly.
5. A Program of Ministry is suggested to promote concepts about aging directed to the middle aged so that they understand their aging parents. He called attention to a workshop projected for February 1981 which is entitled "When Parents Grow Old."
6. Religious education programs should increase understanding of the growing older process.
7. The Churches Committee has been promoting pilot projects in two counties to coordinate efforts between churches and temples and County Councils on Aging.
8. More centers like The Shepherd's Center in Spartanburg need to be developed. This Center is operated by older persons which has been developed around the assessed needs.

Senator Rubin told Dr. Kempson that they appreciate the help from the churches. It has been self-evident for some time that government has its limitations and must depend on the church and civic support.

COMMITTEE ON CHURCHES AND AGING

South Carolina Commission on Aging

The Committee on Churches and Aging has existed for several years officially under the auspices of the South Carolina Commission on Aging. Each religious denomination in the state has been invited to appoint a member to the committee. Dr. Julian Parrish of the Legislative Committee is an active member and so is Ms. Suzanne Lewis from the Division of Health and Human Services in the Governor's Office. The committee has been an advocate for aging, workshops have been conducted and pamphlets prepared for the guidance of churches and temples in developing programs for the older citizens.

Several concerns are expressed by the committee:

1. Who are the aging and where are they in any community? Who really knows? Who cares? Churches and temples are encourage to work with community agencies to answer these questions.

2. Any program for older persons must directly serve their needs. Gay Luce, a California psychologist, in surveying the range of programs routinely available to older people "found them dull, infantilizing and a failure in promoting the strengths and values of later life." Churches and temples are requested to exert their efforts in calling for quality programs which meet needs.

3. The aging should be engaged in determining their needs, plans to meet them and implementation of the same. A Census Bureau report shows that 17 percent of the population will be 65 and older by 2030 and that life expectancy will be over 80 years before that date.

4. There is a greater need of advocacy for and with the elderly. The individual church and temple would be encouraged to actively speak forth on issues that preserve the dignity of the aging. This could be a coordinated effort with the Commission on Aging and the county councils on aging. Concerns for advocacy would focus on the potentialities of older persons, health needs, retirement policies as well as a whole range of issues. The church and temple in their advocacy would recognize older people as fellow human beings and children of God.

5. A program of ministry is suggested for those not yet in the senior citizen category. Such an effort would promote appropriate concepts about aging particularly among the middle aged and would also enable them to understand their aging parents.

   To initiate an effort in this direction, a program in training leaders to carry out workshops on "When Parents Grow Old" is projected for February 1981 under the direction of Mrs. Virginia Stevens, Greensboro, North Carolina, who has been successfully conducting such programs.

6. More effective attempts should be made to increase our understanding about senior citizens among church and temple members and the public at large. Stereotypic thinking about aging must be destroyed and agism

confronted. A recent study reveals that children are ambivalent about older people. Also it supplies data that they have negative feelings about growing old themselves. Beginning in the early years of childhood and continuing through the years that follow, education must be projected about what it means to grow older as a part of the normal life process. Such opportunities should be utilized through the religious education programs.

7. The committee has been promoting pilot projects in two counties for collaboration and coordination of efforts between churches and temples and county councils on aging. Each possesses unique resources about which the other may not be aware. The exchange of information, the greater availability of resources and cooperative endeavors can be of much benefit to older persons on the county and local levels.

8. The Shepherd's Center is a program developed by some churches and the temple in Spartanburg. It fosters adventures in learning, creative workshops, crime prevention, defensive driving, a health enrichment center, summer mini-vacations, supportive home services and tours along with other projects. These programs are geared primarily to middle income older citizens. The response has been exceptionally good. Older persons operate the center which has been developed around the assessed needs. More centers of this nature need to be developed in South Carolina. "A concept worth sharing!"

Dr. Hilda Ross, Director of Mental Health Services to the Aging, South Carolina Department of Mental Health, has said, "The elderly should be recognized as participating citizens with all other people." Certainly this is the aim of our committee.

September 12, 1980

Dr. Hilda K. Ross, Director
Mental Health Services to the Aging
Department of Mental Health
2414 Bull St.
Columbia, SC 29202

Senator Rubin welcomed Dr. Ross who has newly come to South Carolina from Florida and has a great deal of background and experience from other areas.

Dr. Ross stated that the premise from which all her efforts will derive is based on returning to the elderly control for their self-care and management of their futures to the limit of their abilities. She would like to see a majority of the elderly participate on every decision-making body concerning their population.

She shared with the Committee the scope of her professional focus which will be looking at the services and programs for the elderly in major public institutions, agencies and Community Mental Health Centers.

She pointed out that 45 percent of the admissions into one institution could have been handled with present community resources and did not require extensive and high-cost hospital services.

It is projected that in the 65 and over age group, there will be an increase of 22.3 percent by 1986 in South Carolina—almost double that for the rest of the population. The national average figure for elderly likely to need some kind of mental health services is 25 percent. If South Carolina is at the national average, then the Department of Mental Health will be faced with the care of approximately 82,500 people; i. e., unless present procedures can be changed and new uses of existing resources can be created. Dr. Ross will be in the field for the next few months trying to asses and plan a realistic model for the mid-80's.

She mentioned that even though there will never be enough money or qualified personnel to do the job in the next six years, number of staff is not at issue but quality. She urged that only the best technicians trained in gerontology/geriatrics in medicine, nursing and psychology-social care should be considered for new positions.

Her first efforts, however, will be directed at the current process of commitment of elderly persons to psychiatric hospitals. She called the on-going practice of shuttling older patients back to their counties "tantamount to patient abuse." A patient must make two separate trips, one to be examined by two physicians and counseled by an attorney, and the other one to a Probate Judge, to satisfy the statutory commitment process. Dr. Ross took that ride with some patients and said that the human suffering was unbelievable. She referred to eating in the van on a hot day at noon as some patients can not walk into a restaurant or eat in public. Before an unwell patient is allowed to take the commitment trips, a doctor certifies that the patient "can make it." Have we come to "survival" in order to satisfy a mandate, Dr. Ross asked the Committee.

Senator Rubin told Dr. Ross that she has given the Committee some real concerns and the Committee will be in touch with her as to what can be or should be done.

FOR HEARING
September 12, 1980

By: Hilda K. Ross, Ph.D.
Representing
S.C. Department of Mental Health

I am priviledged to appear here today, Mr. Chairman and Honorable Members of the Committee. In the few weeks that I have been here, I have learned about some of the services and programs you have been pursuing with commendable results. I expect that catching up with all your achievements and current activities will take me several months.

First, I would like to share with you the premise directing my professional focus and where this philosophy will take me in my work with the Department of Mental Health as its new director of Mental Health Services For The Aging, and second, to bring to your attention a matter deserving immediate action. First, the premise from which all my efforts derive is based on returning to the elderly control for their self-care and management of their futures to the limit of their abilities. Too often, the benevolent development of services FOR the elderly fulfills its own prophecy. The early aging person minimizes his inner resources and strengths to acquiece to the onslaught of care because now he is "old". To avoid over-servicing, I would like to see a majority of elderly participating on every decision-making body concerning their population.

I will be looking at the services and programs for the elderly in the major public institutions, agencies and Community Mental Health Centers, and since so much that occurs internally is impacted by what is going on in the community, I will become acquainted with those activities as well. Working jointly with professional people and the elderly to identify imperatives and to implement mutually agreed resolutions should further the well-being of the elderly of South Carolina. You have already laid a good foundation, and I would consider myself priviledged to be invited to join in your efforts.

Slowing down the revolving door into public institutions is a national problem and is a problem for South Carolina as well, I quickly discovered. At present 45% of the admissions into one institution could have been handled with present community resources and did not require extensive and high cost hospital services. A responsive system of community care involving more than Community Mental Health Centers must be developed, for they cannot do it alone, and I will tell you why.

Through sheer weight of the elderly 65 and over projected for South Carolina, we will see a 22.3% increase by 1986, almost double that for the rest of the population. The national average figure for elderly people likely to need some kind of mental health services is 25%. If South Carolina is at the national average, then the Department of Mental Health and all the agencies touching the lives of the elderly will be faced with the care of approximately 82,250 people; that is, unless we can reorder the present procedures and create new uses of existing resources. To this end then, I will be in the field for the next few months trying to understand, assess and plan a realistic model for the mid-80's. I want to know the constellation of community services which will help accomplish these aims and, for each community, I expect they will differ. I also want to become acquainted with the environment of the institutions serving South Carolina's elderly.

You are already moving in this direction and I am encouraged because there will never be enough money or qualified personnel in the next six years to handle this large number. By the way, the number of staff is not at issue but the quality of the staff. I urge that only the finest technicians trained in gerontology/geriatrics in medicine, nursing and psychology-social care be considered for new positions. As we move into the 80's we want the best productivity for the money.

In effect then, I will be formulating a plan through which the young-older person can learn to care for herself, as much as possible, physically and mentally, by handling emergency problems through the use of community resources, to the other end of the spectrum of care, the quality of living in institutions for the few who need it.

As important as this is, my first effort is with the current process of commitment to psychiatric hospitals as it effects the elderly. In learning about this process, I also read many other documents that included patient rights, confidentiality, long-term care and formal statements presented before Claude Peppers Senate Committee On Aging Hearings. The strong thread of concern for the elderly was clear but this concern apparently stopped short with the on-going practice of shuttling older patients back to their counties.

The patients must make two separate trips, one to be examined by two physicians and counseled by an attorney, and one to a Probate Judge, to satisfy the statutory commitment process and I am deeply disturbed by this. It is in direct antithesis to everything this Committee and the State of South Carolina has clearly stated. I took that ride and point out emphatically that it is tantamount to patient abuse. I observed the heightened state of agitation brought on by the fear of the unexpected. The human suffering was unbelievable. No wonder no one else wants to take the ride. For five hours of travel, I kept saying, "I can't believe this, it's inhuman". Try eating lunch inside the Van on a hot day; (cold days must be just as difficult.) Some patients could not eat in public; others could not walk into the restaurant so there we were hidden in a hot Van eating at high noon. "I'm hot" lamented one lady, and I instantly thought of the dangers to the elderly from the extremes in heat and cold and these extremes bring on real health hazards. I also thought of the voluminous research data on stress: raised blood-pressures, increased confusion, palpitation, and stroke.

Initially, when we tried to get started, one lady refused to get into the Van saying that she would not because she "did nothing wrong". The only way to get her into the Van was to gently but firmly help her in. She fought back to regain her independence and her locus of control. I thought of the scientific material that tells us that taking this control away depletes the human spirit. It was absolute dehumanization. It is not what they are in the hospital for. Broken in spirit, she relented and sat mute for most of the day; however, on the return trip, she tried to get out of the Van declaring her right to leave. She and I were equally incapable of understanding why this was going on. Now I must ask, what has happened to allow this to continue?

Right now, while we sit comfortably, three or four people are being sent out ....while nurses, the mental health specialists, the doctors, the administrators know it is a travesty and feel helpless to stop it. Did you know that before an unwell patient is allowed to take the commitment trips, a doctor certifies that the patient"can make it"? In other words, that he can survive the trip. Have we come to "survival" in order to satisfy a mandate?

Perhaps the very frail elderly have found their role in our technical society, not for their sakes so much as for ours, compelling us to work together in the name of humaneness so we can experience once more the bonding of people for the benefit of others.

Thank you.

Pete Gustafson
Route 3, Box 47-C
Winnsboro, SC

Mr. Gustafson appeared as a citizen and spoke of a personal experience he and his family have encountered when caring for family members in declining health. His statement is on the following pages.

Senator Rubin thanked Mr. Gustafson for his statement and told him that he has pinpointed certainly one of the greatest problems which confront us today with respect to older people; i. e., the absence of provision for the middle income group—those people who are not the indigents whereby they would qualify for assistance under the Federal guidelines. He mentioned a most interesting article in NEWSWEEK magazine—where this columnist wrote about his aunt who had worked all her life and was very productive, etc.—telling of this same situation.

Senator Rubin promised that the Committee will do all they can to move along in this area as rapidly as they can. "I am afraid it will take a long time, but I sure do appreciate your coming," he told Mr. Gustafson.

REMARKS TO THE STUDY COMMITTEE ON AGING

BY Pete Gustafson
Rt. 3, Box 47-C
Winnsboro, SC

Mr. Chairman, Members of the Committee, I am Pete Gustafson a citizen and represent no organization. I feel as though I have had a great deal of experience in dealing with senior citizens and I appreciate the opportunity to be here today.

In my opinion, South Carolina through and understanding General Assembly and others such as the Commission on Aging, has made considerable progress in making life better for our senior citizens. One of the finest programs for our senior citizens is the Meals on Wheels program. Members of my family have used it at one time or another. A friend of mine in Fairfield County serves as one of the volunteer delivery men. He has often remarked that the described meal is probably the only nutritionally adequate meal some of our senior citizens receive. Regarding my personal situation, I have had a mother-in-law in a nursing home for five years; two aunts to die in nursing homes in the past three years. My mother has been in a period of declining health for the past four years and has lived with my family the past two years. I know what it is to break into a house at night and pull an elderly person out of the bathtub after not being able to get out. I remember one case where someone fell around 8 in the morning and was discovered in the afternoon at 4 p.m. still on the floor. My mother-in-law has five children and each contributed to her nursing home expenses and her savings were used and they were exhausted. Frankly we were saved when the General Assembly raised the income limitation in the 1979-1980 Appropriation Bill.

My wife and I have taken care of my mother in our home the past two years. Her condition is poor and she cannot walk without assistance and uses a wheel chair. Someone has to bathe her and attend to other personal matters. My wife is not employed and she does most of the care. Occassionally we have help for a half of day or so. I assist her at night and on the weekends. My mother is a retired state employee and her total inocme is around $80.00 over the present cap. We are just a middle class family and should she have to go to a nursing home for a long period of time, we would be in a financial dilemma. Frankly, I do not know how we would handle it.

I am sure there are others in South Carolina in the same position as my family. They are the people who have paid the bulk in taxes over the years .... the middle class families.

I note in your Eleventh Annual Report on page 9, you address this matter and I quote from it now...

"Medically Needy" Program

The Committee agreed to continue to seek coverage of the elderly who are medically indigent. The 1979-80 Appropriation Bill raised the income limitation for Medicaid eligibility for immediate and skilled nursing care to $624.60, the federal limit. Persons having incomes below this amount can be cared for under Medicaid. Persons who have incomes above $624.60, but not enough to pay the actual cost of care, between $1000.00 $1200.00 monthly, can be categorized as "medically needy."

The problems of the "medically needy" are critical and are being addressed by a task force mandated by the legislature and created by the Department of Social Services. This task force is chaired by Gwen Power, Special Assistant to the Commissioner, and is in the process of reviewing medical coverage options and eligibility. Final recommendations have not been submitted to the Health Care Planning and Oversite Committee."

I respectfully request your careful consideration be given to the matter and hope some solution will be found to assist our senior citizens and their families who face this dilemma in these inflationary times. Thank you very much for giving me time to appear before you this afternoon.

Bill Garrett, Director
Adult Services
Department of Social Services
P. O. Box 1520
Columbia, SC 29202

Mr. Garrett asked the Committee's support of the following requests in the 1981-82 budget:

1. State funds of $521,812 to employ 192 additional homemakers. This would be cost beneficial to the State as in many cases disabled elderly could be maintained in the home and costly institutionalization could be avoided or at least delayed. At present, DSS is able to assist approximately 50 percent of the clients in need of this service.
2. Funds to employ 114 Careworkers. Two years ago, DSS was able to get a CETA grant which enabled them to employ 10 careworkers and 1 supervisor in the following 5 counties: Lancaster, Chester, Fairfield and Newberry counties. Richland County was added on later. This Program made it possible to employ AFDC mothers. Most of the women employed under this Program have teenage children ready to leave home and also most of these women have no skills and very little education. The Department has contracted with the TEC Centers where these women receive some training similar to nursing assistants or nursing aides. However, most likely these CETA funds will not be extended since the agency has already exhausted the time limit on this Project. DSS is requesting continued funding under Title XX and State funds for FY 1981-82. A total budget of $1,029, 248 is projected; Federal Title XX dollars would amount to $771,936--State sum needed to match is $257,312.
   In their budget request, the initial five counties are included and service has been expanded to Berkely, Orangeburg, Greenville, Sumter and Williamsburg counties, where the highest percentage of the total population over 65 receives Medicaid benefits.

On the Medically Needy Program, Mr. Garrett stated that if additonal funds are available, DSS can choose to expand its Medicaid coverage by adopting this Program. Under this Program, the State may eliminate the "cap" on nursing home services, which is now at $714 per month.

For FY 1982 the Program would cost $8,794,212, or $2,690,895 in State dollars.

DSS is studying the implementation of this Program in South Carolina and will very shortly have a more detailed report on this and other Medicaid options for expanding coverage.

He spoke on a pilot program for the provision of Title XIX Medical Transportation utilizing a taxicab company. This arrangement provides medical transportation to offset the loss of transportation services by the Charleston Economic Opportunity Council and seems to be working satisfactorily.

Senator Rubin asked if the State provides the funds for this pilot program.

Mr. Garrett told him that Title XIX is Medicaid funds, approximately 30 percent of these funds would come from the State.

Senator Rubin commented that these are urgent needs in a year of financial crunch, but that we will keep working on the problems. He expressed his appreciation for the far-ranging services of DSS. He mentioned that he hears a good bit of criticism in the foodstamp area. Mr. Conrad appeared before the Budget and Control Board and asked for an additional appropriation for the foodstamp program, and Senator Rubin wanted to know what type of follow up or surveillance DSS is able to provide. He realizes that the indigent people need this; however, what damages any program are the people who take advantage of it.

Mr. Garrett told the Committee that they have a fraud unit which investigates suspicious cases. In the larger counties, however, you cannot imagine the number of people who come in during the day applying for foodstamps. Each worker has a certain quota of people to process, and it is almost impossible to verify all the information. You have to have a pretty good reason to suspect somebody and turn them over to the fraud unit.

Senator Rubin asked Mr. Garrett to check into this as, in his opinion, this needs more attention.

Dr. Parrish wanted to know in reference to the requested 192 homemakers what kind of training they propose for these workers and what is the time established for training.

Mr. Garrett replied that they will spend one week in the county office to learn the basic job requirements and then they receive additional training for about another month. Mr. Garrett was not sure exactly how long they will be trained.

Dr. Parrish added that the Committee has been strong in its emphasis of good training before these workers go into homes.

(Prepared statement on the following pages).

SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES

STATEMENT PRESENTED TO
LEGISLATIVE STUDY COMMITTEE ON AGING
September 12, 1980

The South Carolina Department of Social Services in its 1981-82 Budget Request to the General Assembly, is requesting additional funds to expand and improve services to the elderly. We would appreciate the committee's support of our request in the 1981-82 budget request for:

Funds to Employ 192 Additional Homemakers

The Department is requesting $521,812 in state funds to employ 192 additional homemakers (These funds would be used to match $1,565,438 in federal funds). This request is being made due to the growth in caseload and due to the inadequate number of staff at the present time. This program is cost beneficial to the state because in many cases elderly, frail, or disabled individuals can be maintained in their own homes thus reducing or delaying the need for institutional placement and the ensuing high costs. At the present time, the Department is able to assist approximately 50% of the clients in need of the service.

Funds to Employ 114 Careworkers

The Careworker Program involves the hiring and training of AFDC recipients to care for elderly, handicapped, and disabled persons who need supportive personal care services in order to remain in their own homes. Funds are provided through a CETA Public Service Employment Grant. The project became operative October 13, 1978 in Lancaster, Chester, Fairfield, and Newberry Counties. Richland County was added November 5, 1979. A request for funding has been submitted to the Governor's Office CETA Division for FY 81. If approved, this will cover the period October 1, 1980, through September 30, 1981. Due to the unlikely extension of CETA funds, since the agency has already exhausted the time limit of eighteen months on this project and is continuing under an extension of time, we are requesting continued funding under Title XX and state funds for FY 1981-82. A total budget of $1,029,248 is projected. Federal Title XX dollars would amount to $771,936. The state sum needed to match is $257,312.

In the budget request, we have included the initial five counties and expanded the service additional counties (Berkeley, Orangeburg, Greenville, Sumter, and Williamsburg). These were selected from data collected on the highest percentage of the total population over 65 that receive Medicaid benefits.

Accomplishments of the Program

Since the initiation of this program a total of 84 AFDC mothers completed the required training and worked or continue to work on the project. Thirty-five of these ladies have found jobs in the private sector.

A total of 163 clients have been given careworker services. At the present time, 82 elderly, handicapped and disabled individuals are being served. According to doctor's statements in each client record, these individuals would need nursing care if this service should become unavailable.

The benefits of this program include savings when:

Clients are able to avoid institutionalization,
AFDC mothers are able to become self-supporting,
Title XX services, food stamps, and medicaid benefits are reduced and,
Psychological benefits are gained by all concerned.

Medically Needy Program

If additional funds are available DSS can choose to expand its Medicaid coverage by adopting the Medically Needy Program. Persons that meet all the eligibility requirements for SSI or AFDC except the income requirement would become eligible to receive Medicaid. (Persons on SSI or AFDC are currently eligible). These new eligibles would have to meet a spend down requirement. That is, they would have to incur a certain amount of medical expenses that Medicaid would not pay for before becoming eligible. (The exact amount they would have to incur depends on their income and the maximum AFDC payment in South Carolina.) Under the Medically Needy Program the state may eliminate the cap on nursing home services (now at $714 per month).

The projected impact is as follows:

1) For FY 82 the program would cost $8,794,212 or $2,690,895 in state dollars.

2) Approximately 55% would be spent on the disabled.

3) The aged would receive few additional services since they are now covered by Medicare.

4) More aged recipients would be competing for the same number of nursing home beds.

DSS will very shortly have a more detailed report on this and other Medicaid options for expanding coverage.

Community Long Term Project

This project was discussed earlier by Mr. Tom Barnes. The Department of Social Services actively supports this project and Mr. Conrad continues to serve as Chairman of the Long-Term Care Council.

BDG/las
9/11/80

PILOT PROGRAM FOR THE PROVISION OF TITLE XIX MEDICAL TRANSPORTATION UTILIZING A TAXICAB COMPANY

On January 31, 1980, the Title XIX Medical Transportation Contract with Charleston Economic Opportunity Council terminated. Charleston E.O.C. elected not to renew the contract because of their inability to operate within the reimbursable ceiling established by DSS. Volunteer transportation was not available in the county in a sufficient quantity to handle transportation needs.

Finally, on June 4, 1980, a contract was signed with Charleston Yellow Cab Company to provide medical transportation to offset the loss of transportation services by Charleston E.O.C. Transportation is provided on a demand-response, "portal to portal" basis at a rate of $.75 per passenger mile with a maximum ceiling of $5,000.00 per month.

The taxi company dispatchers attempt to contact by phone every passenger on the day of service to confirm taxi pickup time. Most clients have been at home and ready when the driver arrived for pickup.

This arrangement seems to be working out quite satisfactorily.

BDG/las
9/11/80

William V. Bradley
State Ombudsman
Edgar A. Brown Building
Columbia, SC

In 1976 the cap for the income limitation was $310; the average cost of stay in a nursing home was approximately $800. The gap then was $500. Today, in 1980 we raised the cap to the Federal maximum which is $714, but at the same token, health care has escalated to the point where a stay in the nursing home is $1,200. So, regardless how hard the Committee and the General Assembly works, there is still a $500 gap. The only way to alleviate this situation will be to adopt the Medically Needy Program.

One other area that concerns Mr. Bradley is the lack of low income housing. There are a lot of complexes, however, he found out that certain housing units only have to have 30 percent of the units occupied by those with low income. The people who need the low income housing can not get it.

Senator Rubin wanted to know if he was referring to housing under the State Housing Authority or Federal Programs.

Mr. Bradley replied that this was housing under the Federal Programs.

Senator Rubin wanted to know if this is a Federal stipulation by law or regulation.

Mr. Bradley thinks that it is a regulation.

(Prepared statement on the following pages).

REPORT TO
LEGISLATIVE STUDY
COMMITTEE ON AGING

PREPARED BY
WILLIAM V. BRADLEY

SEPTEMBER 12, 1980

SENATOR RUBIN AND MEMBERS OF THE LEGISLATIVE STUDY COMMITTEE ON AGING, THANK YOU FOR THE OPPORTUNITY TO PRESENT A FEW OF MY IDEAS ON THE NEEDS OF OUR ELDERLY.

THE COST OF LIVING CONTINUES TO INCREASE EACH YEAR AT AN ALARMING RATE, A PACE GREATER THAN THE FIXED INCOMES OF OUR ELDERLY CITIZENS. THIS IS ESPECIALLY TRUE FOR THOSE WHO NEED LONG TERM HEALTH CARE OR HOSPITALIZATION. EACH OF YOU HAS WORKED VERY HARD TO HAVE THE MEDICAID CAP RAISED EACH YEAR. THIS WAS ESPECIALLY TRUE LAST YEAR WHEN THE CAP WAS RAISED TO THE MAXIMUM OF 300% OF THE SUPPLEMENTAL SECURITY INCOME. AS YOU ARE AWARE, THE CAP IS NOW $714.00 PER MONTH; HOWEVER, THE AVERAGE COST IN A NURSING HOME IS $1,200.00 PER MONTH. THIS IS ROOM AND BOARD; DRUGS, DOCTOR BILLS AND OTHER SERVICES ARE EXTRA.

IN 1976 THE MEDICAID CAP WAS $310.00 AND THE AVERAGE COST IN A NURSING HOME WAS $800.00 PER MONTH. THIS MEANS THAT EVEN THOUGH THE CAP HAS INCREASED 2½ TIMES, AN INDIVIDUAL IS STILL APPROXIMATELY $500.00 SHORT OF BEING ABLE TO PAY HIS MONTHLY BILL.

IT SEEMS THAT NO MATTER HOW HARD YOU WORK TO RAISE THE CAP, WE ARE NOT CLOSING THE GAP.

THIS DEFICIT HAS REMAINED CONSTANT FOR THE PAST SEVERAL YEARS. IT APPEARS TO ME THAT IF WE ARE EVER GOING TO CLOSE THIS GAP, WE WILL HAVE TO ADOPT THE MEDICALLY NEEDY PROGRAM.

SOME PEOPLE WILL PROBABLY SAY THIS IS A NEW PROGRAM; HOWEVER, I WOULD LIKE TO TAKE THE APPROACH THAT IT IS A REALLOCATION OF FUNDS. THE DEPARTMENT OF SOCIAL SERVICES LISTS THE MEDICALLY NEEDY PROGRAM AS A NUMBER ONE PRIORITY. I HOPE YOU AND OTHER MEMBERS OF THE GENERAL ASSEMBLY DO LIKEWISE.

THE SICK AND FRAIL ELDERLY WHO WORKED HARD, PAID THEIR TAXES, AND TRIED TO SAVE FOR THEIR RETIREMENT ARE NOW HAVING THE DOOR CLOSED IN THEIR FACES. I ASK - HOW MUCH LONGER CAN WE IGNORE OUR ELDERLY WHO VERY DESPERATELY NEED THIS CARE?

I PLEAD WITH YOU AND OTHER MEMBERS OF THE GENERAL ASSEMBLY TO LOOK AT THE APPROPRIATION BILL AND TO SEARCH YOUR CONSCIENCE TO DETERMINE IF THERE IS A GREATER NEED THAN THAT OF OUR ELDERLY.

THERE IS ONE OTHER AREA THAT I WOULD LIKE TO BRING BEFORE YOU TODAY. OUR OFFICE HAS HAD AN INCREASED NUMBER OF CALLS AND LETTERS CONCERNING HOUSING FOR THE LOW INCOME. SHELTER, OF COURSE, IS ONE OF THE ESSENTIALS OF LIFE. RECENTLY, I HAD A CALL FROM A LADY WHO HAD BEEN ON A WAITING LIST FOR TWO (2) YEARS FOR LOW INCOME HOUSING. I KNOW WE HAVE A SHORTAGE OF NURSING BEDS AND LONG WAITING LISTS; HOWEVER, I THOUGHT THERE WAS PLENTY OF LOW RENT HOUSING. THERE ARE A LOT OF COMPLEXES, BUT I LEARNED A LESSON WHILE I WAS TRYING TO RESOLVE THIS PROBLEM. I DISCOVERED THAT CERTAIN HOUSING UNITS ONLY HAVE TO HAVE THIRTY (30) PERCENT OF THE UNITS OCCUPIED BY THOSE WITH LOW INCOME. WITH A PROVISION LIKE THIS, THE ELDERLY HAVE A LIMITED NUMBER OF HOUSING UNITS AVAILABLE TO THEM.

EVERYTHING HAS INCREASED IN PRICE WHICH MEANS THAT THOSE ON FIXED INCOMES, AND THIS INCLUDES THE ELDERLY, ARE JUST TRYING TO MAKE ENDS MEET. TWO HUNDRED AND THIRTY-EIGHT DOLLARS ($238) A MONTH, WHICH IS THE STANDARD PAYMENT AMOUNT FOR SSI, DOES NOT GO VERY FAR WHEN THE POWER OR ENERGY BILL EQUALS THE RENT.

IT IS MY FIRM BELIEF THAT THE ELDERLY WHO ARE HAVING TO EXIST ON A SOCIAL SECURITY CHECK ARE HAVING A HARDER TIME NOW THAN AT ANY OTHER TIME IN THEIR LIFE.

WE ALL KNOW THAT THE ELDERLY POPULATION IS INCREASING EVERY YEAR. I WOULD HOPE THAT THIS IS THE YEAR THAT THE ELDERLY is the [redacted] NUMBER ONE PRIORITY of the General Assembly. WE SIMPLY CANNOT AFFORD TO FORGET NOR NEGLECT THE PEOPLE THAT FOUGHT AND WORKED HARD TO PRESERVE OUR GREAT STATE.

FROM THE BOOK THAT IS THE ALL-TIME BEST SELLER, I QUOTE, "CAST ME NOT OFF IN THE TIME OF OLD AGE, FORSAKE ME NOT WHEN MY STRENGTH FAILETH."

I KNOW I CAN COUNT ON EACH OF YOU TO USE YOUR WISDOM AND BEST JUDGEMENT WHEN YOU CONSIDER THE NEEDS OF THIS MOST DESERVING GROUP OF GREAT PEOPLE - OUR ELDERLY.

THANK YOU VERY MUCH FOR LETTING ME EXPRESS MY THOUGHTS HERE TODAY.

Edith Smith, Director
Home Health Services
Department of Health and Environmental Control
2600 Bull St.
Columbia, SC 29201

Ms. Smith addressed five areas which are directly related to in-home health care in South Carolina.

1. Title XX Health Support and Homemaker Services
   DHEC's contracts to provide health support and homemaker services were not renewed for this current year. DHEC had provided services under Title XX with the intention to fill gaps in home health care. They are providing essential nursing and personal care services to the homebound, chronically ill and frail elderly to prevent institutionalization. This concept has not been well received by the agency administering the Title XX funds. The SSAC (Social Services Advisory Council) and the Governor's office have endorsed an amendment to the Title XX plans to allow DHEC to provide the nursing component of the Health Support Services. The DSS Board has delayed action on this recommendation.
2. Certificate of Need for Home Health Agencies
   This was implemented July 1, 1980. Two new agencies have received their CoN; three new applications are pending.
3. Medicaid Coverage of the "Medically Needy"
   Many elderly manage relatively well on fixed incomes until illness strikes. Addition of medical expenses not covered by Medicare places an impossible burden on their budget. Limitation of Medicaid coverage to the "categorically needy" (i. e., the blind, disabled, families with dependent children) leaves elderly persons without resources to meet these additional expenses. Expansion of Medicaid coverage to include the "medically needy" would ease the economic burden.
4. Institutional Bias in Health Insurance Coverage
   Ms. Smith recommended that the Legislature consider requiring the

inclusion of home health care as a basic benefit in insurance plans sold in the State. She said that several states have passed legislation mandating inclusion of home health care in basic health insurance benefits. Traditionally, insurance coverage has been on payment for medical expenses incurred in institutions.

5. Effect of "Head Count" and Budget Cuts on Services for the Elderly.

Appropriate and increased use of home health care in reducing hospital stays and delaying institutionalization has increased demand for services. The Long Term Care Project in Appalachia III has identified additional people in need of services. Hospice programs, both community and hospital-based, contract with the Health Department to provide the home health care portion of their programs. PSRO reviews of Medicare and Medicaid nursing home applicants identify people who can manage at home with home health care. If State agencies, including DHEC, are not able to increase direct caregiver staff to meet these increased demands for service, the results will be institutionalization and waiting lists.

Ms. Smith recommends that the Legislature consider granting an exception or establishing a different category of State position for caregivers employed on earned or Federal funds.

Senator Rubin asked if she is suggesting that the inclusion of home health care as a basic benefit in insurance be mandated or made optional. Also, he wondered if this would not appreciably increase the cost of the insurance.

Ms. Smith replied that this be a mandatory part of the insurance coverage written by private insurance companies in South Carolina. She referred to legislation passed in New York State where the average premium increase was $2 for a year's period for a family coverage.

Senator Rubin thanked Ms. Smith for her informative presentation.

Senator Rubin, members of the Joint Study Commission on Aging, distinguished guests:

My name is Edith Smith and I represent the Division of Home Health Services of the Department of Health and Environmental Control. We share your concerns for the welfare of our state's older citizens and appreciate this opportunity to share our ideas with you. The support of this committee and the Commission on Aging has been instrumental in passage of legislation implementing previous recommendations such as the Long Term Care Project, increased funding for home health services for the medically indigent, licensure and certificate of need requirements for home health agencies and appropriation of Title XX match funds for Health Support.

Today, I will address five areas that are directly related to the provision of in-home health care in South Carolina.

1. Title XX Health Support and Homemaker Services

For several years DHEC has provided services under Title XX. Our intention in participating has been to fill in gaps in home health care. Our services have focused on prevention of ill-health, management of chronic disease and promotion of health related to avoidance of institutionalization. This concept has not been well received by the agency administering the Title XX funds. DHEC's contracts to provide Health Support and Homemaker Services were not renewed for this current year; however, through the efforts of Senator Rubin, the state funds appropriated to match Title XX federal funds were approved to allow phasing out services to persons whose needs could not be met by other agencies. Without Title XX funds the gap we had sought to close reopens--the homebound, chronically ill and frail elderly do not have available to them nursing and personal care services which offers them a viable choice between institutional and home care.

We are providing essential nursing and personal care services to these people--but we cannot continue without additional funds. The SSAC and the Governor's Office has endorsed an amendment to the Title XX plans to allow DHEC to provide the nursing component of the Health Support service. The DSS Board has delayed action on this recommendation.

RECOMMENDATION:

That the FY 82 Title XX State Plan include funds for health support and personal care services to the chronically ill.

2. Certificate of Need for Home Health Agencies

The certificate of need amendment to the licensure law was implemented July 1, 1980. The Bureau of Licensure and Certification has issued certificates of need to two new agencies; three new applications are pending. The Home Health Services Division will continue to work collaborately with other home care providers to increase the availability and the access to home health care within the state.

3. Medicaid Coverage of the "Medically Needy"

Many older citizens manage relatively well on small fixed incomes until illness strikes. The addition of medical expenses not covered by Medicare places an impossible burden on an already "stretched to the limit" budget. The limitation of Medicaid coverage to the "categorically needy" (i.e. the blind, the disabled, families with dependent children) leaves many of the elderly without resources to meet these additional expenses.

Expansion of Medicaid coverage to include the "medically needy" would ease the economic stress felt by many of the elderly.

RECOMMENDATION:

That the State Legislature consider the feasibility of expanding the State Medicaid plan to include the "medically needy".

4. Institutional Bias in Health Insurance Coverage

The focus of insurance coverage has traditionally been on payment for medical expenses incurred in institutions. Several states have passed legislation mandating inclusion of home health care in basic health insurance benefit. This places home health care on a start-even basis with institutional care and removes "economics" as a barrier to choice.

RECOMMENDATION:

That the Legislature consider requiring the inclusion of home health

care as a basic benefit in insurance plans sold in the state.

5. Effect of "Head Count" and Budget Cuts on Services for the Elderly

The focus of the four previous topics has been on increasing availability and accessibility of home health care to the elderly citizens of the state. The location and service capacity of other home care providers has not diminished the statewide need for DHEC's services. Appropriate and increased use of home health care in reducing hospital stays and delaying institutionalization has increased demand for services. The "head count" effectively limits our resources to provide essential bedside care of the sick.

The Long Term Care Project in Appalachia III has identified additional people in need of services. Hospice programs, both community and hospital-based, contract with the health department to provide the home health care portion of their programs. PSRO reviews of Medicare and Medicaid nursing home applicants identify people who can manage at home with home health care. If state agencies, including DHEC, are not able to increase direct caregiver staff to meet these increased demands for service, the results will be institutionalization and waiting lists.

RECOMMENDATION:

That the Legislature consider granting an exception or establishing a different category of state position for caregivers employed on earned or federal funds.

I appreciate very much the opportunity to speak to you today. I will answer any questions you may have.

Barbara W. Moxon, Chairwoman
S. C. Commission on Women
Suite 307
2221 Devine St.
Columbia, SC

Mrs. Moxon presented the following legislative recommendations to the Committee:

1. Equitable distribution of property
2. Garnishment of wages
3. Survivors' Benefits
4. Intestate Succession
5. Displaced Homemaker
6. Domestic Violence

Complete text of statement on the following pages.

Senator Rubin assured her that he is sympathetic toward the inequities addressed. However, it will all take time.

(Prepared statement and draft of Bill on Division of Marital Property at Divorce on the following pages).

South Carolina Commission on Women

STATEMENT BEFORE PUBLIC HEARING OF THE S.C. STUDY COMMITTEE ON AGING

Senate Chambers, September 12, 1980

I am Barbara W. Moxon, Chairwoman of the S.C. Commission on Women. Our Commission is a small state agency whose function is to study the status of women and their legal treatment in all facets of living, particularly in regard to any discrimination that may exist. We are to make recommendations for change to those governmental leaders who can effect such change and disseminate information related to the rights, responsibilities and status of women.

We have done legal research and an analysis of S.C. laws and procedures which are sex biased, and research on the legal rights of women in relation to wills and estates, credit, marriage and divorce, parental rights and responsibilities, education, employment, property rights, and health care. This information we have published in free pamphlets and is the basis for some of our recommendations to you today. Other recommendations come from the many calls and letters we receive requesting help and information.

A study of female vs. male employment in state government done by our Commission two years ago showed female salaries clustered heavily in the lower-paying jobs, a situation we hope you and others in state government will note and help to rectify.

Now for some specific legislative recommendations which we believe will benfit the elderly and particularly women.

1. Equitable Distribution of Property

Our Commission solciits your support for a bill that would provide for equitable distribution of property at divorce where discrimination against women, and often the older woman, now exists. We have drafted such a bill and secured the interest of several lawyer senators and House members for sponsorship in the next General Assembly session. The bill defines marital property with certain exceptions, and lists specific criteria to be considered by the court when making an equitable distribution of this marital property. This includes the contribution of a spouse as a homemaker. Such legislation would greatly help older citizens, and especially women, to have a fairer share of resources should a divorce occur. We would welcome your willingness to co-sponsor such a bill and include our draft herewith.

2. Garnishment of Wages

We ask your action to promote introduction and passage of a statute to permit garnishment of wages for alimony and child support. There are large numbers of women in S.C. who have difficulty collecting their alimony and child support granted by the court. A woman can return to the court, if her husband is not paying, and ask for a contempt order against him, but she may have to wait several months to have her case heard. Then if her husband (or ex-husband) is found in contempt, he can be sent to jail, but this does not get her any support. If S.C. permitted garnishment for child support and alimony only, the wife (spouse) could receive her support check directly from her husband's or ex-husband's employer. This would particularly be helpful to wives of members of the Armed Forces since under federal

law wages of federal employees and the military can be garnished but only if the state where the person resides permits it. Such a bill was introduced last year but did not get out of committee. Please note this would cost the state no money.

3. Survivors' Benefits

We recommend passage of a bill requiring that a spouse be left a designated share, a specific percentage, of his or her spouse's estate.

4. Intestate Succession

Somewhat related to this is a recommendation on intestate succession. We suggest that the law be changed to read that when a person dies without a will -- intestate - that where there are surviving children, the spouse be entitled to one half of the deceased's property. At present it is one third. This would greatly aid our older citizens at no cost to the state.

Where there are no surviving children, we recommend the spouse receive the whole estate. At present she or he receives the whole estate only if there are no surviving parents, brothers or sisters.

5. Displaced Homemakers

These are people, usually women, who have devoted many years to homemaking and suddenly find themselves, through separation, divorce or death, without a spouse and insufficient income to support themselves. Often these women have no marletable skills, Some do not even know how to apply for a job. They do not know what training is available nor what kind of training they should take. If our definition of a displaced homemaker places her between the ages of 35 and 62, she is too young for social security and ineligible for other public benefits. Many are completely overwhelmed by the necessity of managing their own finances, property and insurance, and coping with all the responsibilities of carrying on life alone after having a partner who shared these matters.

It is estimated that there are over 38,000 displaced homemakers in S.C. While several of our Tech Schools and other agencies have developed programs to help the displaced homemaker, these are only a drop in the bucket compared to the need. With state financing being so tight I am afraid it is too much to hope that you could promote a new program like this, but the need is there and we felt we must call it to your attention once again.

6. Domestic Violence

This is a growing area of concern to many of us, and weighs heavily on women and often older women. There are few resources in S.C. - centers to go for temporary care and counselling - for wives who have finally decided they can no longer take being beaten regularly. Having children to consider compounds the problem.

A bill in Congress to address this problem has passed the House but is in trouble in the Senate. Our own U.S. senators have told me they feel it is not a problem the federal government should step into. It's a state problem they say. But the state and local governments are doing nothing, or little. True DSS and the Columbia Area Mental Health Center offer some help and a few private agencies like the YWCA and Providence Home are struggling to address the problem, but they need help. Our USC Medical School has been seeking funding to make a survey of the extent of domestic violence in S.C. Perhaps when we have real data on the size of the problem, state officials may be more eager to take action. We hope so.

In summary may I point out that four of our legislative recommendations would cost the state no money whatsoever: equitable distribution of property, garnishment of wages, survivors benefits and intestate succession.

Thank you for your concern for older women. Our Commission will be happy to work with you on some of these problems within the limitations of having only one staff person. We would be glad to have any information you feel beneficial to women considered for publication in our new quarterly newsletter for S.C. women.

S. C. Commission on Women

FEBRUARY, 1980

DRAFT OF BILL ON DIVISION OF MARITAL PROPERTY AT DIVORCE

IN A PROCEEDING FOR DISSOLUTION OF THE MARRIAGE, SUPPORT AND MAINTENANCE OR DISPOSITION OF PROPERTY FOLLOWING A DECREE OF DISSOLUTION OF THE MARRIAGE BY A COURT WHICH LACKED PERSONAL JURISDICTION OVER THE ABSENT SPOUSE, OR LACKED JURISDICTION TO DISPOSE OF THE PROPERTY, THE COURT SHALL, AND IN A PROCEEDING FOR SUPPORT AND MAINTENANCE, MAY, FINALLY EQUITABLY APPORTION BETWEEN THE PARTIES THE MARITAL PROPERTY (AS THE TERM IS DEFINED BELOW) OF THE PARTIES. IN MAKING APPORTIONMENT THE COURT SHALL CONSIDER THE DURATION OF THE MARRIAGE, MARITAL MISCONDUCT, ANY PRIOR MARRIAGE OF EITHER PARTY, ANY ANTENUPTIAL AGREEMENT OF THE PARTIES, THE AGE, PHYSICAL AND EMOTIONAL HEALTH, STATION, OCCUPATION, AMOUNT AND SOURCES OF INCOME, VOCATIONAL SKILLS, EMPLOYABILITY, ESTATE, LIABILITIES, AND NEEDS OF EACH OF THE PARTIES, CUSTODIAL PROVISIONS, WHETHER THE APPORTIONMENT IS IN LIEU OF OR IN ADDITION TO MAINTENANCE AND THE OPPORTUNITY OF EACH FOR FUTURE ACQUISITION OF CAPITAL ASSETS AND INCOME.

THE COURT SHALL ALSO CONSIDER THE CONTRIBUTION OR DISSIPATION OF EACH PARTY IN THE ACQUISITION, PRESERVATION, DEPRECIATION, OR APPRECIATION IN VALUE OF THE RESPECTIVE ESTATES, AND THE CONTRIBUTION OF A SPOUSE AS A HOMEMAKER OR TO THE FAMILY UNIT.

THE TERM "MARITAL PROPERTY" AS USED HEREIN SHALL MEAN ALL PROPERTY IN WHICH THE PARTIES HAVE AN INTEREST EXCEPT THE FOLLOWING:

(A) PROPERTY ACQUIRED BY EITHER PARTY PRIOR TO THE MARRIAGE;

(B) PROPERTY ACQUIRED BY EITHER PARTY BY INHERITANCE, GIFT, DEVISE OR BEQUEST;

(C) PROPERTY ACQUIRED BY EITHER PARTY IN EXCHANGE FOR PRO
PERTY ACQUIRED BEFORE THE MARRIAGE OR BY INHERITANCE, GIFT,
DEVISE OR BEQUEST.

(D) PROPERTY EXCLUDED BY VALID AGREEMENT OF THE PARTIES.

BUT SHALL INCLUDE ANY INCREASE IN VALUE IN PROPERTY ACQUIRED
BY EITHER PARTY PRIOR TO THE MARRIAGE UNLESS SUCH PROPERTY
IS EXCLUDED BY (D).

James A. Crawford, Director
Regional Aging Program
Santee-Lynches Council For Governments
P. O. Box 1837
Sumter, SC 29150

From personal experience, Mr. Crawford is aware of the many needs of senior citizens; however, today, he wanted to bring only one need to the Committee's attention. He asked that positive action be taken to help the older worker find employment. He urged the Committee to require employers to have Affirmative Action Plans for older people--beginning with the State of South Carolina as an employer. (Prepared statement follows).

Senator Rubin asked if his Council for Governments has been in touch with the employers, the business people who do the hiring, to ask for their help and enforce the idea.

Mr. Crawford said yes they have done all that; however, there still seems to be the syndrome started prior to World War II when the mandatory retirement age was set at 65. The law changing this to 70 was a step forward for those employed then and employed now. But it did not help those who are not employed. "The older people deserve the same special attention of Affirmative Action Requirement that the other minorities get."

Dr. Parrish asked for the ratio of unemployment in Mr. Crawford's community at this time; whether there was a surplus or shortage of workers in the major industries or is it peculiar only to senior citizens.

Mr. Crawford said that there are no statistics available on this matter as older people quit--many have given up and lose hope. He does not want to call it peculiar only to senior citizens, but he wants to state that it is a special problem.

Senator Rubin commented that they are inhibited by what they consider a traditional bias, and with some encouragement they would try harder.

Mr. Rushton added "with some special legal encouragement."

Senator Rubin thanked him for the statement.

SANTEE-LYNCHES
COUNCIL FOR GOVERNMENTS
Serving Clarendon, Kershaw, Lee and Sumter Counties

September 12, 1980

Mr. Chairman and other Honorable Members of the State of S.C. Study Committee on Aging, I appreciate this opportunity to present to you a matter that I consider vital to the well being of many older South Carolina Citizens. I am a Senior Citizen and I speak today from personal experience. I also am Director of the Area Agency on Aging for Santee-Lynches Council for Governments and I speak for the experience and opinions and hopes of older people in Clarendon, Kershaw, Lee, and Sumter Counties.

Senior Citizens have many needs. However, today I'm talking about only one need. The need I'm talking about is for those who want and need to take care of themselves financially, to earn the money for their daily bread. They are physically, mentally, and emotionally capable of doing an excellent days work. They will bring experience, proven know how, maturity of judgement, sound work habits, unusual motivation to be productive and self supporting and a special added ingredient -- pride in being recognized as valuable people.

Unfortunately, most older people find employment doors either closed or only slightly ajar. Many cannot get their applications taken and if so, rarely get interviewed. Many have given up -- many are losing hope. They say loud, clear, and imploringly "We don't want hand outs - we want paychecks". "We want to be a part of society not apart from society".

The law changing mandatory retirement from 65 to 70 was a step forward for those employed then and employed now. The problem concerns those not employed now. The Law prohibiting discrimination in employment because of age is also a good step forward. But it lacks the positive action -- the vitality and goal setting necessary to make it work -- I am talking about Affirmative Action. It was the Affirmative Action Requirement that placed action into removing non discrimination based on race, color, national origin, and sex. The principle of Non Discrimination is passive without Action -- and Action is not always Voluntary.

Positive Action is needed to help the former Older Worker become a Now Worker. I urge you to require Employers to have Affirmative Action Plans for Older People -- beginning with the State of South Carolina as an employer. Treat us as a special "Minority" deserving and requiring special action. It will help the older persons, the employers, society, and the tax payers. I believe it is the step now necessary to help end job discrimination against older people. Thank you!

Respectfully,

James A. Crawford, Director
Area Agency on Aging

Susan R. Carlton, Director
Retired Senior Volunteer Program
1800 Main St., Suite 3-C
Columbia, SC 29201

The Retired Senior Volunteer Program (RSVP) has been in operation in South Carolina since 1973 and is sponsored by the Richland-Lexington Council on Aging. There are 490 people over 60 years of age actively serving in 52 different agencies, schools and hospitals in the two-county area. Each month they are contributing about 5,000 hours of volunteer service.

There are a total of nine RSVP's serving 14 counties in the State. Each month a total of 4,000 senior volunteers give at least 32,000 hours of service. The cost per volunteer was computed at 55 cents. This was done by the Action Agency which funds all their Programs. All the Programs in South Caroline are sponsored by the Councils on Aging, except for the Charleston area, they are sponsored by the American Red Cross.

Ms. Carlton did not appear to ask for money, instead she offered these volunteer services. However, she urged the Committee's consideration of some appropriation in the future of maybe $1,000 or $2,000 to each RSVP or to the Councils on Aging. This small appropriation could be used to reimburse a few more older people who could not otherwise afford to volunteer.

She asked why State Government has not taken this cost effective approach of investing in volunteer programs as the hospitals did long ago with such good results. She believes that RSVP volunteers could help State agencies right now and asked that the Committee provide her with a list of some of the State Government positions that are now being frozen.

She requested that everything possible is done to improve the provision of transportation to the volunteers by making better use of the vehicles we have in all our agencies; such as creating a central transportation office.

In closing she said that we need to take action to maximize this potential, even if it takes time and money.

September 12, 1980

Susan R. Carlton
Retired Senior Volunteer Program
1800 Main St., Suite 3-C
Columbia, S.C. 29201

The Retired Senior Volunteer Programs have, as you know, been in operation in South Carolina since 1973. I am proud to be the director of the RSVP program sponsored by the Richland-Lexington Council on Aging. We now have 490 people over 60 actively serving in 52 different agencies, schools, and hospitals in the two county area. Each month they are contributing about 5,000 hours of volunteer service - a contribution that enriches their lives and ours and that the community would not have received otherwise.

Recently ACTION awarded a new RSVP grant to the Williamsburg County Council on Aging. Now a total of nine RSVP's are serving 14 counties in the state. Between us we have more than 4,000 senior volunteers giving at least 32,000 hours of service a month. ACTION computes the cost per volunteer hour to be 55¢, very cost efficient when one considers the value of the services rendered and the enhanced self-esteem and sense of purpose of each senior volunteer involved.

The kinds of assignments volunteers are doing range from the fairly conventional to the unusual, challenging, and creative. Volunteers are doing advocacy as well as service delivery, they are designing senior center programs as well as enjoying them, setting up accounting systems as well as helping with paperwork, establishing pre-retirement planning programs as well as participating in them.

The great joy of RSVP's philosophy is that older people have the chance to do almost anything that the community needs. It lends itself to creativity,

growth, and service. The ingredients for success have been the volunteers, the support of paid and volunteer staff who recruit, encourage and place them, the cooperation of agencies who request the volunteers' services, the transportation we provide to volunteers who do not drive, and the reimbursement we offer those on fixed incomes who could not afford the gasoline expenses incurred in volunteering.

This year we have received the first increase in federal funds since 1973. Even though the money basically serves to offset the inflation of the past 7 years, all the programs are expanding their services and recruitment of volunteers. There are many more community needs to be met and potentially hundreds of older people for us to recruit to meet them. However, provision of transportation is a constant struggle and more volunteers, hard hit by inflation, are requesting reimbursement. Someday soon we are going to reach our limit.

I am not asking you for money! Indeed, I'm here to offer you volunteer services. But I do urge you to consider appropriations in the future that will enable older people to have the option of doing community service in their retirement. Even an appropriation of $1,000 or $2,000 to each RSVP program or to Councils on Aging where there is no RSVP could be used to reimburse a few more older people who could not otherwise afford to volunteer.

I also urge you to consider the value volunteers can be in your offices and in most state agencies. It is a great mistake not to have a volunteer administrator in every state agency to develop job descriptions, prepare staff to receive and work with volunteers, and to recruit volunteers for the agency. Hospitals learned long ago that investing in their volunteer programs brought enormous returns. Why hasn't state government taken this cost effective approach? It would pay you many times over to invest in volunteer administrators, set aside money for meals for volunteers, and offer

reimbursement for travel or provision of transportation in state vehicles for volunteers who don't drive.

These suggestions to improve voluntarism in state agencies are offerred for your consideration, but I do have a request that you could act on soon. While I can make no promises, I believe that RSVP volunteers could help state agencies right now. Please provide me with a list of some of the state government positions that are now being frozen. Don't hesitate to include leadership positions in the list. Perhaps some of the tasks can be handled by senior volunteers if they were defined clearly and if supervision was provided. I will ask ACTION to forward listings of the jobs in other parts of the state to the other RSVP directors. We may not be able to fill even a small number of the requests, but we can try.

Another request is that you do everything possible to improve the provision of transportation to our volunteers. I don't think that this necessarily means investing in many new vehicles, but instead making better use of those we have in all of our agencies. I would gladly turn over our RSVP van, our driver, and our vehicle operations funds to a transportation system that could help transport many more volunteers in every part of the two county area along with everyone else needing transportation services. So many agencies request one volunteer at this time and another at another time, and even the most skillful planning does not make the best use of our 14 passenger van except when we are transporting a large group. It would be wonderful to call a central transportation office and have our volunteers ride the nearest van, be it full of children or handicapped people, or the elderly!

The only hesitation I would have in relinquishing control of our van is that I do not ever want to hear that a volunteer could not ride in preference to someone needing a congregate meal or a ride to the doctor. I fear this

because those are very real and urgent needs and we tend to regard volunteer work and leisure activity as luxuries in comparison. It is impossible to document, but I firmly believe that RSVP is doing preventive work. Our people are living longer, richer lives because they are doing something useful. They are less likely to need mental health services or institutionalization. Their volunteer work feeds their spirits, and we all know that it is possible to stuff a person full of food and medicine but accomplish nothing unless they have the will to live.

I don't think I have to convince you of the worth of older people and the potential of their contributions to the community. What I do want to say is that it is not enough to talk about it. We need to take action to maximize this potential, even if it takes time and money. The result will be secure, useful older people giving their skills and time to solve some of the many problems that beset us.

Thank you.

William L. Belvin, Jr., Director
Community Treatment Services
S. C. Commission on Alcohol and Drug
Abuse
3700 Forest Drive, Suite 300
Columbia, SC 29204

Mr. Belvin brought to the attention of the Committee the problem of the misuse and, at times, the self-destructive abuse by elderly persons of legal drugs, prescribed and purchased over the counter.

He first focused on that widely-used drug, ethyl alcohol. Older persons encounter three possible difficulties as a result of consumption of this drug: 1) adverse physical reactions from the interaction of alcohol and other medications, 2) Deterioration of physical disorders when an older person drinks, and 3) the illness of alcoholism itself.

Studies have placed the alcoholism prevalence rate among elderly persons anywhere from 2-10 percent. It has been found that nursing home populations have a problem rate as high as 20 percent. For those elderly seen in hospitals for medical, surgical and psychiatric illness the frequency of alcoholism rises to as much as 33 percent. However, the identification of the problem is more difficult among the elderly because many of the symptoms of alcoholism are often similar to symptoms of the aging process.

Shifting the focus from alcohol to drugs, Mr. Belvin said that there is widespread misuse of both prescription and over-the-counter medications by elderly persons. Persons over 65 represent one-tenth of the nation's population; they account for one-fourth of all prescriptions written by physicians. The National Council on Aging has estimated that 20 percent of out-of-pocket health expenses for the elderly goes for the purchase of drugs. Twenty-five percent of suicides occur in persons over 65 years of age, which may be attributed to the ready availability of prescription medications, particularly in sedatives and tranquilizers.

One undertaking, which Mr. Belvin hopes will make a contribution at least to dealing with the problem of the elderly and prescription medication abuse, was the designation of the Governor's Prescription Drug Task Force by Governor Riley on April 2, 1980. The Task Force is composed of repre-sentatives from several State agencies, professional associations, licensing

boards, the Study Committee on Aging, and the Governor's Office. This Task Force has begun a serious examination of the current use of prescription medications in nursing homes. National studies indicate that the use of medications in long-term care facilities is extreme. Forty percent of drugs used in nursing homes are central nervous system drugs, pain killers, sedatives or tranquilizers. Tranquilizers alone represent 20 percent of all drugs used. (Statement on the following pages).

Senator Rubin told Mr. Belvin that he brought some very good data and the problem is big since we are in a pill-taking age and people expect them to cure everything.

TESTIMONY FOR STUDY COMMISSION ON AGING
September 12, 1980

I am Bill Belvin, Director of Community Treatment Services for the South Carolina Commission on Alcohol and Drug Abuse. I am appreciative of this opportunity to bring to the attention of the Study Committee a problem the nature of which is still subject to widely differing "guesstimates," but a problem which, I am convinced, is very real. I speak of the misuse and, at times, the self-destructive abuse by elderly persons of legal drugs, both those which are prescribed and those purchased over the counter.

Let me begin by focusing on that widely-used drug--ethyl alcohol. Older persons encounter at least three possible difficulties as a result of their consumption of this drug. First, there is a possibility of adverse physical reactions resulting from the interaction of alcohol and other medications. Second, there may be the occurrence of deterioration in physical disorders when an older person drinks. To illustrate: alcohol can decrease the cardiac efficiency in individuals with heart disease. Modest doses can raise the heart pressure. The central nervous system of elderly persons is especially vulnerable to the affect of CNS-depressing drugs, and alcohol falls within this category.

The illness of alcoholism itself is the third possibility. Various studies have placed the alcoholism prevalence rate among elderly persons anywhere from 2-10%. It has been found that nursing home populations have a problem rate as high as 20%. For those elderly patients seen in hospitals for medical, surgical and psychiatric illness, the frequency of alcoholism rises to as much as 33%.

Despite such estimates, the identification of the problem may well be more difficult among the elderly than in younger populations. Many of the symptoms of alcoholism are often similar to other functions of the aging process, and may be misread by an examining physician. Social isolation of many elderly persons makes the task of detection fall more heavily on outreach efforts of social service personnel and the diagnostic skill of physicians. The denial on the part of the elderly alcoholic is extremely great. Family members tend to overlook the self-destructive element in the elderly alcoholic, preferring to believe that drinking is one of the few pleasures left to the aging and they should be allowed to obtain pleasure in what few alternatives remain.

Shifting the focus now to drugs other than alcohol, it is clear that the problem is certainly not one of drug addiction. Indeed, it may be an overstatement to speak even of abuse. Clearly, however, there is widespread misuse of both prescription and over-the-counter medications by elderly citizens. To begin with, while persons over 65 represent one-tenth of the nation's population, they account for one-fourth of all prescriptions written by physicians. The National Council on Aging has estimated that 20% of out-of-pocket health expenses for the elderly goes for the purchase of drugs. While this may seem to suggest overuse, the

problem for the non-institutionalized elderly is more likely to be one of underuse, erratic use, or contraindicated use. This results from several factors, some of which may be directly attributable to the user, many of which can be blamed on the prescriber. I refer, among other things, to medication ommission by the patient, self-selection of too many non-prescription medications, exchange of drugs between patients, hoarding of outdated drugs, inappropriate prescriptions, duplicate prescriptions by more than one physician, etc. Certainly, we must work toward a better informed consumer and a greater sensitization of physicians to the needs of the elderly.

The high frequency of suicides among older persons is exacerbated by the ready availability of prescription medications, particularly the sedatives and tranquilizers. Twenty-five percent of suicides occur in persons over 65 years of age. The rate for males over 65 is five times that for young men and four times the national average. The elderly are more successful in their attempts at suicide, and three-fourths of suicide attempts by elderly persons are made with drugs obtained from their own physician.

What do South Carolina data tell us about the extent of the problem? At present, our available information is fragmentary. For each of the past three fiscal years, an average of 620 persons 65 and older have received service for an alcohol or drug problem in the state's network of county alcohol and drug commissions. This represents about 2.5% of all persons served. The state's largest treatment center, Morris Village, reports an even lower percentage. If, however, one looks at patients 55 years of age and older, then 10% of all admissions to Morris Village fall within this age range. Of female patients served, 13.3% are over the age of 55. Given the problem of denial and the difficulty in problem identification mentioned earlier, the numbers served may well represent only the tip of the iceberg. In a study of admissions to county alcohol and drug commissions conducted some three years ago by Peppers and Stover of the Clemson Department of Sociology, it was pointed out that most referrals were from self, family, or the courts. The absence of referrals from health and social agencies was striking. It seems apparent that some systematic effort to improve client identification and assist the client in gaining access to appropriate helping resources is required.

In closing, I would like to mention one undertaking which I hope will make a contribution at least to dealing with the problem of the elderly and prescription medication abuse. On April 2, 1980, Governor Riley officially designated the Governor's Prescription Drug Task Force "to study the problems of prescription medication abuse in the state, recommend solutions to such problems, and report its finding to this Office and other appropriate groups." The Task Force is composed of representatives from several state agencies, professional associations, licensing boards, the Study Committee on Aging, and the Governor's Office. Within its broad mandate, the Task Force has begun a serious examination of the current use of prescription medications in nursing homes. There have been several national studies indicating that the use of medications in long-term care facilities is extreme. Forty percent of drugs used in nursing homes are central nervous system drugs, pain killers, sedatives, or tranquilizers. The latter category alone represents 20% of all drugs

used. The United States Senate Subcommittee on Long-Term Care found serious concerns including theft and misuse of nursing home drugs, high incidence of adverse reaction, some disturbing evidence of drug addiction, and lack of adequate control in the regulation of drug experimentation. In South Carolina, the Governor's Task Force has raised questions about the amount of drugs used and prescribed for elderly patients in nursing homes. It is our hope that with the availability of additional data, we may be in the position of making sound recommendations for dealing with this particular problem.

WLB/af/8-10-80

George Dick, Planner
Central Midlands Regional Planning Council
Suite 155, Dutch Plaza
Columbia, SC 29210

Mr. Dick's testimony centered on the well elderly and possible means to prolong their wellness. He pointed out that the 75 and over portion of the aging population is the fastest growing segment. This is very important to know since this segment of the population has the highest possibility of being service dependent.

It is most important that we come up with alternate support systems. One such alternate system may be found in the area of PREVENTIVE MEDICINE. For instance, a medical check up—which the elderly rarely seek—could be provided through a mobile staff which would visit within designated communities. This Program which would assess all systems of the body could be for anyone 60 years or older and funded in part by contributions. The examiner could be specifically trained to draw out and answer questions many elderly neglect to ask a physician and then the proper referrals could be made to appropriate physicians, specialists or service provider agencies.

"The basis for our region's interest in this Program comes from the knowledge gathered from a similar Program developed in Iowa," said Mr. Dick. Of the elderly individuals screened in that State's Program, over 40 percent needed to be referred to some type of physician. Because of early detection, ailments could be treated and thus reduce the probability of severe illness and its accompanying dependence and cost.

In closing, he urged the Committee to consider alternate service systems when looking at the needs of the total aging population and to give their support to new innovative programs designed to prolong the well or near well older population. (Statement follows).

Senator Rubin thanked Mr. Dick for his statement and told him that the Regional Planning Council covers a vast amount of territory and is always very helpful. He wanted to know how this screening as preventive measures would be implemented. He knows that DHEC does some of that now.

Mr. Dick said that they contacted DHEC and Central Midlands and they are willing to work with them.

Senator Rubin added that if they had the funding, they could expand. He hopes that Mr. Dick will find funding for this project, as it will be easier than to get it through the Legislature.

MR. CHAIRMAN, MEMBERS OF THE STUDY COMMITTEE, MY NAME IS GEORGE DICK AND I WORK WITH THE CENTRAL MIDLANDS REGIONAL PLANNING COUNCIL AS THE DIRECTOR OF THE UNIT ON AGING. OUR AGENCY SERVES AS THE AREA AGENCY ON AGING FOR THE FOUR COUNTIES OF FAIRFIELD, LEXINGTON, NEWBERRY AND RICHLAND.

IN OUR WORK AS THE AREA AGENCY ON AGING, WE HAVE WORKED, OR CURRENTLY WORK, WITH AROUND 50% OF THE INDIVIDUALS PRESENTING TESTIMONY BEFORE YOU TODAY. WE BELIEVE THE ISSUES THEY PRESENT SURROUNDING HEALTH CARE FOR THE IMPAIRED ELDERLY, EMPLOYMENT, TRANSPORTATION, IN-HOME SERVICES AND A VARIETY OF OTHER NEEDS ARE VALID AND NEED YOUR VERY CLOSE ATTENTION.

I AM HERE TODAY TO SPEAK WITH YOU ABOUT THE WELL ELDERLY PORTION OF OUR GROWING AGING POPULATION AND A POSSIBLE MEANS BY WHICH TO PROLONG THEIR WELLNESS. THE GROWTH OF THE AGING POPULATION IS WELL KNOWN BY EACH MEMBER OF THIS COMMITTEE SO I WILL NOT GO INTO THE DRAMATIC POPULATION CHANGES OUR REGION AND STATE ARE EXPERIENCING. HOWEVER, I WOULD LIKE TO POINT OUT THAT THE 75 AND OVER PORTION IS THE FASTEST GROWING SEGMENT OF THE AGING POPULATION. THE IMPORTANCE OF THIS IS SEEN WHEN RECOGNIZING THAT THIS SEGMENT OF OUR POPULATION HAS THE HIGHEST POSSIBILITY OF BEING SERVICE DEPENDENT.

BECAUSE OF THE DRAMATIC INCREASE IN THIS PROBABLE SERVICE DEPENDENT POPULATION, OUR SERVICE SYSTEM FINDS ITSELF ILL EQUIPPED TO RESPOND IN AN ADEQUATE FASHION. "WHAT CAN WE DO TO BETTER EQUIP OUR SERVICE SYSTEM"?, IS THE QUESTION MOST HEARD TODAY. PERHAPS WHILE LOOKING FOR THE ANSWER TO THIS QUESTION WE WILL NEED TO LOOK FOR ALTERNATE SUPPORT SYSTEMS. ONE SUCH ALTERNATE SYSTEM COULD BE FOUND IN THE AREA OF PREVENTIVE MEDICINE.

ONE SUCH SUPPORT SYSTEM WE BELIEVE NEEDS DEVELOPING WOULD PROVIDE A SERVICE THAT THE ELDERLY RARELY SEEK; A MEDICAL CHECK UP AS A PREVENTATIVE HEALTH MEASURE. THIS SERVICE COULD BE PROVIDED THROUGH A MOBILE STAFF WHICH WOULD VISIT WITHIN DESIGNATED COMMUNITIES ASSESSING ALL SYSTEMS OF THE BODY. THIS PROGRAM COULD BE FOR ANYONE SIXTY (60) YEARS OR OLDER AND FUNDED IN PART BY CONTRIBUTIONS.

THE PROGRAM WOULD NOT ONLY PROVIDE LOCAL PROFESSIONAL HEALTH SCREENING, BUT ALSO REFERRALS WOULD BE MADE TO APPROPRIATE PHYSICIANS, SPECIALISTS, OR SERVICE PROVIDER AGENCIES. THE CHECK-UP COULD INCLUDE SCREENING FOR HYPERTENSION, BLOOD SUGAR TEST, DENTAL CHECK-UP, PAP SMEAR, HEMOGLOBIN, URINALYSIS, T.B. TEST, EXAMINATION OF NOSE, THROAT, ABDOMEN, BREAST, EYES, EARS, AND MUSCULAR SKELETAL SYSTEM.

DURING THE ASSESSMENT A MEDICAL HISTORY COULD BE TAKEN AND THE OLDER PERSON'S PRESENT MEDICATIONS DISCUSSED. SUCH THINGS AS SIDE EFFECTS THE OLDER PERSON MAY BE EXPERIENCING, WHAT MEDICATIONS SHOULD NOT BE COMBINED, AND THE INTERACTION OF PRESCRIPTION MEDICATION WITH NON-PRECRIPTION DRUGS, SUCH AS ALCOHOL COULD ALSO BE DISCUSSED. THE EXAMINER COULD BE SPECIFICALLY TRAINED TO DRAW OUT AND ANSWER QUESTIONS MANY ELDERLY NEGLECT TO ASK A PHYSICIAN.

THE BASIS FOR OUR REGION'S INTEREST IN THIS PROGRAM COMES FROM THE KNOWLEDGE GATHERED FROM A SIMILAR PROGRAM DEVELOPED IN IOWA. OF THE ELDERLY INDIVIDUALS SCREENED IN THAT STATE'S PROGRAM OVER 40 PERCENT NEEDED TO BE REFERRED TO SOME TYPE OF PHYSICIAN, DENTIST, PUBLIC HEALTH OR OTHER SUPPORT AGENCY. ELEVATED BLOOD PRESSURE, ELEVATED BLOOD SUGAR, AND LOW HEMOGLOBIN WERE THE THREE MOST FREQUENT REFERRED CONDITIONS FROM THAT PROJECT. BECAUSE OF DETECTION, THESE AILMENTS COULD BE TREATED REDUCING THE PROBABILITY OF SEVERE ILLNESS AND ITS ACCOMPANING DEPENDENCE AND COST.

I AM HERE TODAY TO ASK YOU TO CONSIDER ALTERNATE SERVICE SYSTEMS SUCH AS THIS WHEN YOU LOOK AT THE NEEDS OF THE TOTAL AGING POPULATION. WE FEEL THIS SERVICE COULD WELL PREVENT UNDUE EARLY INSTITUTIONALIZATION. ALSO, A PROGRAM SUCH AS THIS WOULD BE AN IDEAL ACCOMPANING MODEL TO BLEND WITH FUNDED LONG TERM CARE PROGRAMS, I.E., THE ROBERT WOOD JOHNSON HEALTH IMPAIRED ELDERLY PROJECT FOUND WITHIN THE CENTRAL MIDLANDS REGION.

IN CLOSING, LET ME AGAIN EXPRESS THAT EXISTING PROGRAMS DESIGNED TO MEET THE NEEDS OF THE FRAIL,HEALTH IMPAIRED, AND ISOLATED ELDERLY NEED YOUR FULL SUPPORT. HOWEVER, WHILE GIVING THAT SUPPORT, PLEASE DO NOT FAIL TO SUPPORT NEW INNOVATIVE PROGRAMS DESIGNED TO PROLONG THE WELL OR NEAR WELL OLDER POPULATION.

THANK YOU AGAIN FOR GIVING ME THE OPPORTUNITY TO ADDRESS YOU TODAY. WE LOOK FORWARD TO ASSISTING YOU IN ANY WAY WE CAN DURING THE UPCOMING YEAR.

TESTIMONY PRESENTED BY GEORGE DICK TO THE S.C. STUDY COMMITTEE ON AGING ON SEPTEMBER 12, 1980.

Joan Kershner, Director
Veterans Administration
Wm. Jennings Bryan Dorn Veterans' Hospital
Columbia, South Carolina 29201

Senator Rubin expressed his appreciation to have Ms. Kershner appear and called the Veterans Hospital one of our most important facilities in this area.

Her testimony addressed the following areas of concern:

1. The VA cannot assume the sole responsibility for all the needs of veterans.
2. They cannot provide all extended care services, especially not for non-service connected veterans.
3. One-fourth of all patients at the VA are 65 and over, chronically ill or multiply impaired. They need different kinds of extended care. NCS veterans (non-service connected veterans) are not entitled to unlimited outpatient services. Other resources must be found to meet their needs.
4. There is a great need for an intermediate level of support for elderly couples so they can stay together by providing intermediate living facilities.
5. Respite care for caregivers.
6. More trained people to help the elderly in their own homes.

For the general information of the Committee, she explained that this year they returned over a quarter of a million dollars of their Community Nursing Home Funds, which is a controlled line item in their budget, because of insufficient placement/beds in this State for veterans. (See other statistical data supplied on statement which is on the following pages).

Senator Rubin wanted to know what the usage of the VA facility is at present, whether it was filled up...

Ms. Kershner replied that in their Nursing Home Care they have 120 beds and 119 patients.

Senator Rubin wondered about the numbers in general treatment.

Ms. Kershner informed him that in general treatment they had as of today 82 percent occupancy. They have increased their turn-over rate greatly, due to the Medical School, which means they are treating more

patients. They anticipated treating about 6,000 in-patients this year and so far have exceeded the 8,000 mark, also, they are treating nearly 100,000 out-patients.

Senator Rubin wondered if they are threatened by the Congressional cutbacks.

Ms. Kershner replied that with the escalating costs, all agencies will have to live with an austere budget. One point that needs to be considered is that the elderly enter the health care needs arena in larger numbers today and these people require more time, more work and more assistance. She predicted that this is where the bind will come in the future.

1. Veterans who live in South Carolina are first and foremost citizens of South Carolina. The Veterans Administration responds to many of the needs of veterans, but cannot assume the sole responsibility for all the needs of veterans.

2. The average age of WW2 veterans is increasing; presently it is 60. The Veterans Administration cannot provide all extended care services, especially for non-service connected veterans. NSC veterans are not legally eligible for many services which they might need.

3. In South Carolina, 40 % of all veterans are from periods of service prior to and including world war 2. At the William Jennings Bryan Dorn Veterans' Hospital, approximately one fourth of all patients treated are 65 years of age or older. Many of these patients are chronically ill or multiply impaired. They are in need of different kinds of extended care. However, NSC veterans are not entitled to unlimited outpatient services and other resources must be found to meet their needs.

4. There are many specific needs which are not presently met by existing services. For example, there is a great need for intermediate living facilities where elderly couples can continue to live together with some supervision and assistance. Often one partner is impaired to the extent requiring nursing care. The spouse is not as impaired but is not capable of caring for all the needs of the impaired partner. Such couples need an intermediate level of support between the relatively unsupervised residential "highrise" and the nursing care provided by a nursing home facility.

5. Another priority need is for respite care for caregivers. Often a family member expends enormous efforts for unremmiting periods caring for an impaired loved one. Provision for occasional relief would be of great assistance to these people and would enable them to continue their efforts for longer periods of time.

6. More trained people to help elderly in their own homes are needed. Some programs have been quite successful in training WIN mothers to provide this

type of personal care. Such programs should be fully supported.

7. The list of needs could continue on and on. All of these things require a strong committment of financial support. But the problems of the health-impaired elderly are among the most pressing challenges to society today. These problems are especially deserving of our compassionate and responsive attention.

COMMUNITY NURSING HOME FUNDS TURNED IN.....$328,000
20 Census

VETERANS OUTPLACED

State War Veterans Home ---------	106	
Community Nursing Homes ---------	48	(VA Funded)
	92	(followed by VA but not necessarily funded)
Personal Care Homes ----------	14	

Father Thomas Duffy
Vicar General
Charleston Catholic Diocese
119 Broad St.
Charleston, SC 29401

He suggested encouragement of the following programs:

1. Foster grandparents and visitations of shut-ins by the elderly.
2. Adequate nutritional programs in centers as well as home-delivered meals.
3. Tax credit to families who care for an elderly relative in their homes.
4. Support for the hospice movement.

(Statement on the following pages),

He mentioned that the Housing Authority in Charleston has a regulation which stipulates that residents can only pay in cash.

He urged that we "listen" to the elderly and let those who can take part in our society—they have so much to offer.

Senator Rubin said that Father Duffy's church has certainly done a lot in the housing field, such as Christoper Towers which has received nothing but commendations. He was proud to have been at the groundbreaking and dedication and to have been able to assist with legislation.

I am Father Thomas Duffy, the Director of Catholic Charities for South Carolina. I appreciate the opportunity to speak with you today about the needs of elderly citizens.

More than anything else, I hope that a positive tone will prevail in your recommendations for proposed legislation to help the aging.

Many people seem to have forgotten today that the elderly are not merely a "burden," to be shunted aside from the mainstream of American life, but that they are valuable citizens. Since they have the graciousness and wisdom of age, those who are willing and able should be allowed and even urged to contribute actively to the good of the community.

Certainly, those who are in need must not be made to feel that their lives are not worth living and that they are a burden to society. Men and women who have given so much to us in the course of their lives--as fathers, mothers, and citizens--deserve our love and compassion instead.

Unfortunately, that is not always the case. Many proposals have been made in recent years to reduce the costs of care for the elderly by "allowing them to die." Such trends have become so pronounced that one major scholar, Dr. Germain Grisez, recently concluded "that to a very large extent the systematic killing of dependent persons in our society is going to occur because they often require public support and the flawed sense of justice of the wealthy and powerful is balking at this burden."

The same point was made even more tellingly perhaps by Dr. Victor Rosenblum, a well-known national attorney, who recently remarked that "in our time there is a cult of death that provides the backdrop against which we must view the problems of the sanctity of life ... Our task is not to succumb to this cult of death, but to accept as our first priority developing ways of enhancing life."

With regard to senior citizens, I would suggest encouraging programs such as foster grandparents and visitation of shut-ins by the elderly.

With respect to those in need, I would like to see adequate nutritional programs for the elderly. There is a definite need for centers where elderly people can get adequate food and enjoy the company of other people. There is also a need for having delivery of meals.

Although a recent study by the New England Journal of Medicine indicates that only 5% of the elderly are institutionalized and that 95% of senior citizens are either independent or are cared for by relatives, I think it would be highly desirable to extend a tax credit for those families who take care of elderly relatives in their homes, thereby reinforcing the commitment of many families to the care of the aged.

Similarly, I would like to encourage the legislature to foster the hospice movement, possibly with demonstration grants, so that a high quality of care may be extended to the

dying in South Carolina.

Obviously, many specific proposals might be made, but I think one of the greatest problems in our society is the failure to be aware of the dreams and hopes of others, and I feel that we must move away from a cold professionalism to a real concern for the aged.

Claude Vaughn, Chairman
Legislative Forum
S. C. Federation of Older Americans
3601 Chateau Dr.
Columbia, SC 29240

Mr. Vaughn presented the following items for consideration:

1. Natural Death Act. Continue support of the legislation.
2. Uniform Probate Code.
3. Improvement in the S. C. Judicial System.
4. Health Care Issues for the elderly. Find better ways to accommodate the health-impaired elderly.
5. Equalize S. C. personal exemption ($800) with Federal ($1,000).

Senator Rubin told him that the exemption will go up some by legislation which was passed last year. It will be related to the inflationary index, but at least up to 6 percent cap. So, there will be some improvement in this area. He expressed his appreciation for Mr. Vaughn's suggestions.

(Statement on the following pages).

Claude Vaughn

P. O. Box 12344 1226 Bull Street
xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
xxxxx 29211

August 28, 1980

The Honorable Hyman Rubin
Chairman, S. C. Joint Study
Committee on Aging
The State House
Columbia, South Carolina 29201

Subject: ~~Items for~~ presentation at the public hearing September 12, 1980.

Dear Senator Rubin:

The Legislative Forum of the South Carolina Federation of Older Americans, in a recent meeting, directed the chairman of that forum to inform the Joint Study Committee on Aging about some of the concerns to be considered during the next General Assembly. This forum made up of retired executives from government, industry, education and representatives from state and local governments are eager to work with the Joint Study Committee on Aging to bring about meaningful legislation on the following items:

1. Natural Death Act - We recognize and appreciate very much the efforts you and many other members of the Senate did in pushing this legislation through the last session of the legislature. We feel that it was most unfortunate the House could not find the time or place to bring the "Act" before the full body of the House for discussion. Perhaps this year success could and will come to those who have worked so diligently for passage of this legislation.

2. Proposed Changes to the Uniform Probate Code - Some members of the Legislative Forum have worked on sub-committees studying the changes and we have had input from various judges and attorneys who support these changes as being essential to expeditious handling of many probate matters.

3. Improvements in the South Carolina Judicial System. Some members of the Legislative Forum attended the recent Citizens Conference at USC where thorough discussions were held regarding the need for such improvement. We whole-heartedly support some form of legislation to improve our Judicial System.

4. Health Care Issues for the Elderly - While we realize there are several on-going projects being undertaken and stuided, our main concern is that we urge the appropriate legislative and/or administrative bodies to continue efforts to find better ways to accommodate the health impaired elderly as expeditiously as possible.

5. Finally, Mr. Chairman, we urge your help in balancing a tax burden for all South Carolinians in passage of legislation that will equalize the amount of personal exemption imposed by the S. C. Tax Commission ($800.00) with that of the Federal exemption of $1,000.00 annually. This would not be a significant change but would help in a small way to relieve some of the tax burden.

Again, our thanks to you, this committee and the entire General Assembly for your past favors and your consideration on the above issues.

Respectfully submitted,

Claude R. Vaughn, Chairman
Legislative Forum

CRV/bf

Josie K. Claiborne, Project Director
Aging Program
Columbia Urban League
P. O. Drawer J
Columbia, SC 29250

Statement listing 12 areas of concern is on the following pages.

It is late in this session, surely but not too late for this state to move to improve the lives of its elderly citizens. As an advocate for the rights of senior citizens, it is imperative that I call to your attention the major areas of concern that require some corrective action. With the ever increasing numbers of elderly people the problems that are in existence today will be intensified if something is not done now to alleviate or eradicate the problems facing our elderly citizens.

The state of South Carolina should:

(1) Allocate monies to pay a state supplement to SSI Benefits. We are one of the last states in the nation to do this.

(2) Expand available supportive services to elderly persons trying to maintain an independent life-style outside of an institution. This would reduce inappropriate institutionalization. Studies have shown that staying home is a matter of life & death because institutionalization results in rapid deterioration of the condition of an elderly person.

(3) Expand available supportive services to families who are trying to maintain elderly parents or relatives in their homes. Such services as Adult Day-Care & Financial Assistance could receive the burden of caring for an elderly relative in these days of inflation & give the caring person a break from the tasks of daily care.

(4) Promote the development of personal care housing for the elderly which would allow the elderly to live in their own units but have assistance available when needed.

(5) More housing & rental payments assistance. The state could supplement the federal efforts in this area.

(6) Victim assistance for elderly victims of crime.

(7) Legislation to require the reporting cases of elderly abuse by caseworkers & Medical Personnel. This would be similar to child abuse reporting legislation.

(8) Expand Medicaid eligibility. Cost-of-living increases in Social Security can result in the loss of Medicaid eligibility. With the rising cost of Medical Care, Medicaid costs alone can & do eat up the entire Social Security benefits checks of many older citizens.

(9) Provide more & better low-cost public transportation to increase access to available services.

(10) Provide energy payments assistance or lifeline rates for the elderly or other forms of rate structure reform to relieve the burden of high utility costs. (Lifeline rates basically freeze at a low rate the first 250 to 600 kwh of electricity a residential customer uses a month.)

(11) Increase weatherization efforts to reach more homes.

(12) Increase the availability of advocacy & legal assistance for elderly persosn in the public benefits area. Elderly persons need intervenors to deal with the increasing complexity & unresponsiveness of the public benefits system.

Basically, there are three (3) things which determine the quality of life we enjoy - sufficient income, good health, and adequate housing. Meeting these basic needs are what we should be about. We all recognize cutting budgets and cutting services are the concerns of many in government. This paring down continues eventhough most financial experts agree that it will not even put a dent in the rate of inflation we are experiencing. One columnist has said that there is a certain "meanness of spirit" loose in this country today which contradicts the more giving and humane spirit which has characterized some aspects of this country's development. We should not allow this meanness of spirit to reduce the services to the elderly or to forestall the expansion of available services.

Thank You

Josie K. Claiborne
Project Director
Aging Program
Columbia, South Carolina

Sister Sue Beaton
Catholic Church Representative
912 Confederate Avenue
Columbia, SC 29201

In her presentation, Sister Beaton spoke of the problems which elderly renters experience. She thinks that the tenant-landlord relationships need to be reformed.

She spoke of "rip-off" insurance practices relating to burial insurance.

On the "lifeline" rates, she would like to see this Committee advocate for a lower rate than Southern Bell has offered.

(Full text of presentation on the following pages).

Senator Rubin thanked Sister Beaton for appearing.

I would like to start by thanking Senator Hyman Rubin and the members of the Study Committee on Aging for this opportunity to testify regarding the needs of the aging.

I must also express thanks for scheduling me at the end of the day. You see, I believe that after a long day of listening - the last one to appear is a welcomed relief. Also, I hope that be being last, I'll leave a lasting impression on your minds.

You probably are tired... a different kind of tired from the people I'm going to tell you about. Many I represent today are tired over the struggle and energy it takes to get basic needs met. I have tried to create a composite picture of the many elderly I have worked and talked with these past three years. By presenting these real, firsthand experiences in story form, rather than in statistics, I hope you'll feel as uncomfortable as I do in realizing such situations exist.

Annie is 72 years old living in a downtown neighborhood. She has lived there for years. She has seen the character of the area change over the years, but has claimed it as her home. Annie is unique - besides being elderly, she has some major strikes against her - she is a renter, living on SSI. Coupled with society's view on the elderly, she has some real problems.

Annie's income is about $238 per month, her rent $150 (it was $70, but she had to move due to revitalization), heating for one month last winter was $230. Unfortunately, her situation is not atypical of many other Senior Citizens. Simple mathmatics will demonstrate that Annie's expenses oftentimes averages 50% more than her income.

Being a renter, and living in a less than energy efficient home, Annie has to contend with landlords who believe that profit is more important than people. The federal government can continue to try to subsidize her utility bills, and Annie can continue to beg, but the money will never be enough to subsidize substandard housing - and the outdoors will continue to be heated at the expense of wasted taxpayers dol Perhaps the problem could better be addressed by reforming our present tenant-landlord relationships established by law and by mandating the implementation of lifeline utility rates. I would like to comment on both areas for a moment.

Presently, the law in South Carolina controlling what happens between landlords and tenants is generally the same unchanging law that determined those relationships hundreds of years ago - principles which have been adopted from the laws of fuedal England regulating the rental of a tract

of land for the primary purpose of growing 10 acres of barley. Where no agreement to the contrary exists, a landlord has no duty to provide a tenant with a safe and decent home. Even if a tenant rents what s/he believes to be a safe and decent home, and it is not, the landlord is not required to do any work on the unit. In our case, the renter is elderly, on a fixed income and trapped in a situation where her options are few. Her life in the future might not wait for local ordinances to get passed. A broader solution is in order.

Central Midlands Regional Planning Council in a 1978 report entitled: "housing for the Low and Moderate Income Elderly and Handicapped Population", states that "the problem for low to moderate income elderly and handicapped persons is an ever increasing need for shelter for which they are less and less able to pay." Until more adequate housing is built, until laws governing tenant-landlord relationships are reformed, until utility reforms are implemented, the "Annie's of life" will continue to "beg their way to heaven".

Speaking of "begging their way to heaven", I would like to share another plight in Annie's life. It has to do with "rip-off" insurance practices relating to burial insurance. You see, Annie can't read or write, so she can be easily taken advantage of. Sitting on Annie's porch it is common to see insurance agents making their collections. In reading Annie's policy, payments stop when she dies, so conceivably, she can eventually pay 3 times as much for her small $500 policy. Annie never realized that. Her main fear is that she won't die in dignity. The "Annie's of life" will sacrifice food money inorder to pay on their little policies. Unlike SCE&G and Southern Bell, Annie does not receive a 12% rate of return on her policy. I ask - is it fair for the powerless poor to be taken such advantage of?

There are many other concerns that relate to Annie, but perhaps I could mention one more. Annie, as you can expect has no phone. This Committee knows how much of a lifeline a phone can be in breaking down isolation and dealing with emergency situations. Southern Bell, because of the efforts of hundreds of Senior Citizens, agreed to an experimental lifeline rate in four prefixes within the Columbia area. I believe another experiment is going on in Florence. The original request of $5.00 for the first 25 outgoing calls and 5¢ for each call thereafter was not granted. Southern Bell offered a trial $6.75 for the first 25 calls and 10¢ thereafter. As of July 1, there were well over

700 subscribers to this service. I think this is incredible given the little publicity Southern Bell has done on promoting such a rate. I would like to see this Committee advocate for a lower rate. Southern Bell is now asking for another $39.6 million. This will mean an increase of $2.05 monthly for a single-line, as well as a $10.35 increase in connecting charges (up from the present $55.65 charge). The cost of installing a phone makes it most difficult for the many "Annie's of life" to have a lifeline. They would consider the phone a luxury item; when we all know that life experience indicates just how much of a necessity a phone is to a Senior Citizen. Annie can't beg for a phone, so she lives without one. She doesn't much care about rate of returns, just surviving.

This Committee has a long list of accomplishments on behalf of Senior Citizens. I,too, along with the many speakers who have preceded me, would like to express my thanks for your long list of achievements to date. I would hope that in your future deliberations you would consider to advocate for legislative changes, especially those that will help the "Annie's of life" live out the remainder of their days in dignity. It is my prayer that we will help each other grow old graciously rather than fearfully. Thank-you.

Respectfully submitted by:
Sister Susanne Beaton
September 12, 1980

STUDY COMMITTEE ON AGING

James McAden
1247 Sumter St.
Columbia, S. C.

Mr. McAden spoke on the housing problem which faces the elderly. He said that consideration should be given to amending the State Housing Act, which, he thinks, is designed for single unit housing mainly, so as to provide low-cost loans or loan guarantees for large housing complexes for the elderly.

(Statement on the following pages).

Needs of the elderly are dear to my heart, and perhaps are becoming somewhat nearer to my heart.

The biggest problem, as I see it, for the elderly -- right now and in the future -- ll be their housing.

We all live in smaller houses, and both partners in a marriage are more often than not working. There is no space in the homes of today for the revered parent or aunt; if there is, there is no one at home to look after them.

We are perhaps lookin g at what in the future will be our country's most grievous sociological problem.

Housing complexes for the elderly are not necessarily demeaning to the residents. If properly operated, they can be places of enjoyment and good company, plus decent food.

rivate, non-profit organizations are sponsoring such housing, often with financial help from the Federal Government.

But there is not enough of it, and financing is hard to arrange. Some consideration might be given to amending the State Housing Act (which, as I understand is designed for single-unit housing mainly) so as to provide low-cost loans or loan guarantees for large housing complexes for the elderly.

The problem won't go away. Is is abounding, and will continue to grow because of increasing longevity.

James McAden

James McAden

Robert F. Bowles, N. H. A.
Administrator for Saluda Nursing Center
P. O. Box 398
Saluda, South Carolina

Mr. Bowles presented recommendations which were based on his ten years of experience as a licensed nursing home administrator, six years as Director of an E.M.S. system in South Carolina as well as comments he had heard at recent community forums for the White House Conference on Aging. He was representing the South Carolina Health Care Association.

His list of eight recommendations is on the following pages.

Senator McLeod wanted to know how the Medicaid Program discriminates against the non-profit nursing homes, as Mr. Bowles had stated in item No. 4 of his presentation.

Mr. Bowles explained that the Medicaid Program allows a return on equity to a profit-making facility, there is no such mechanism for a non-profit making facility. At one time there was, but there is not now. Therefore, the reimbursement rate is lower for the non-profit facility. County institutions, such as the one of which he is administrator, are forced to and want to serve all people; they provide social services and outreach services which goes beyond what a private facility would be expected to provide.

Senator McLeod wondered if all of them are not on a percentage cost.

Mr. Bowles said that the percentage cost would be on a cost mechanism. Private homes are paid a return on equity, non-profit homes, county or State, are not paid a return on equity. This would apply to the State Hospital or county institutions, such as the one in Saluda County.

Senator McLeod wanted to know what the answer is to the shortage in nursing home beds. As it stands right now the General Assembly, because of the cost getting out of hand, put a limit on the number of beds. In the past you could have as many as you wanted to, but then the State got stuck with the bill after the fact.

Mr. Bowles wished he knew the answer. He knows what the action is doing to the waiting list. That is why he suggested day care, some people say home health care. "We cannot afford to let patients who need institutionalization go without it."

Mr. Bowles said again that one of the answers is to allow nursing homes, without penalizing them, to provide day care which would allow a lot of people to stay at home at lot longer or maybe never go into a nursing home and to provide the other services people ask for, such as, regular home health. However, you are never going to do away with the fact that there are a large number of people who need institutional care. In his facility are 132 patients, and he does not know of a single one--if other alternatives were offered--who would leave. Also, there are 200 people on a waiting list waiting for a bed; home health care and day care would be helpful. Patients say that they would like to see more public institutions, such as the one in Saluda County. There are a lot of counties that do not have nursing homes, and people would like to stay in their counties. Mr. Bowles would like to see these counties have county institutions, and he believes with some inducement and some changes in the Medicaid Program, counties could be encouraged to build institutions. The ratio of private, profit-making nursing homes to public, non-profit nursing homes is 85 percent to 15. He would like to see this 15 percent ratio changed to 20 or 25 percent public, non-profit nursing homes or church homes. He thinks that they could help each other, learn from each other, and the public interest would be best served by balance.

Senator McLeod asked what his solution is to the "all or nothing" cap Mr. Bowles referred to.

Mr. Bowles said that we need some type of spenddown, some type of co-payment for families that can afford it. Right now we do not consider a family's income at all. He told the Legislators that it is up to them to introduce some legislation which would remedy this situation.

Senator McLeod commented that every year we increase the cap and invariably there is someone who is $1 above that limit. To make a co-payment, as Mr. Bowles called it, workable how would he propose to go about it.

Mr. Bowles mentioned that DSS has come up with different formulas that allow a spenddown. He has patients who receive maybe $700 - $800 per month, but there is no way they can come up with the additional money that it would take for an institution. It costs approximately $38 per day in his nursing home.

Senator Rubin remarked that there is a Task Force set up to study the "Medically Needy" Program.

He expressed his appreciation to those who attended the Hearing. "It has been a long day, a very helpful one and very constructive, and the Committee will proceed to analyze the recommendations."

September 12, 1980

Presentation to Senate Study Committee on Aging

The State of South Carolina must continue to improve the health care system for our older citizens.

The following are recommendations for action by the State based upon recommendations that I have heard at recent community forums for the White House Conference on Aging. Also, some of the recommendations are based on ten years experience as a licensed nursing home administrator and six years as Director of an E.M.S. System in this State.

(1) Legislation should be passed that would direct DHEC and DSS to promulgate rules that would encourage nursing homes to provide day care.

(2) The Legislature should monitor the Medicaid program to insure that patients receive the level of care needed as determined by the patient physician.

(3) Too much time is spent by licensed nurses shuffling papers instead of providing patient care. DHEC should be mandated to reduce nursing home paper work by 10%.

(4) The current Medicaid program discriminates against the non-profit nursing homes. Many people believe the continued growth of non-profit facilities should be encouraged.

(5) There needs to be some financial assistance for patients whose income is too high for Medicaid, but who cannot afford nursing home care.

(6) Patients should be encouraged to spend a night out of a nursing home without being harassed by agencies cutting off their assistance.

(7) The State should insure that the Commission on Aging and other groups keep the public informed of the services provided by long term care facilities. It is important to help people avoid institutional care when possible. But, those efforts must not take away from the importa of nursing homes. The State should not make families feel guilty when their loved one needs long term care. The State should not make patients feel their family does not love them because they agreed with the patients doctor that they needed nursing home care.

(8) The State should monitor EMS costs so that the elderly population who are more likely to need these services are not deprived of said servi s. Even now many elderly refuse to call for an ambulance when it is needed due to increasing costs.

Submitted by:

Robert F. Bowles, N.H.A.
Administrator of Saluda Nursing Center, Saluda, SC; a 132 bed long term care facility
Representing S.C. Health Care Association (SCHCA)
Member American College of Nursing Home Administrators
Member of SC State Board of Examiners for Nursing Home Administrators

ADDENDA

Written testimony received prior to Hearing is on the following pages.

Joe S. Dusenbury, Commissioner
S. C. Vocational Rehabilitation Department
P. O. Box 4945
Columbia, SC 29240

South Carolina
Vocational Rehabilitation Department

J. S. DUSENBURY
EXECUTIVE OFFICER AND COMMISSIONER

301 LANDMARK CENTER, 3600 FOREST DRIVE
P. O. BOX 4945
COLUMBIA, SOUTH CAROLINA 29240

August 18, 1980

Ms. Keller H. Bumgardner
Director of Research and Administration
P. O. Box 142
Columbia, South Carolina 29202

Dear Ms. Bumgardner:

Recently, I received an invitation to participate in the annual Public Hearing on the older citizens of South Carolina. Although our Department will not be presenting verbal testimony, we do wish to offer a statement of support for the efforts made by the Study Committee on Aging. Although Congress established the Vocational Rehabilitation program basically to rehabilitate working age individuals, our Department has always recognized the needs of the older worker and has endeavored to serve them in our Rehabilitation program.

The Vocational Rehabilitation Department has worked very closely with the Commission on Aging through various grant programs in providing medical services to older Americans who have been selected for these various programs. The grants provide the funds and Vocational Rehabilitation works closely to insure that services are rendered as prescribed in the grants. In those instances where older Americans have been rendered eligible for Vocational Rehabilitation services, the normal delivery system has been made available according to the individualized needs of the person.

Presently, we are making a concerned effort to serve the severely handicapped individuals, i.e., persons with heart and circulatory problems, orthopedic deformities or functional impairments. It is our opinion that many South Carolinians with these disabilities can return to a productive life whereby they realize vocational and economic security. Of course, adequate personnel and case service funds must be available to provide appropriate services on an individual basis to this group.

We solicit the Committee's support in our efforts to provide Vocational Rehabilitation services to more older citizens of the state.

Sincerely,

Joe S. Dusenbury
Commissioner

JSD:sr

Brittie C. Bellamy, Executive Director
Horry County Council on Aging, Inc.
2231 W. Main St.
Conway, SC 29526

Horry County Council on Aging, Inc.

2213 N. MAIN STREET
CONWAY, SOUTH CAROLINA 29526
TELEPHONE (803) 248-5523

August 28, 1980

State of South Carolina
Study Committee on Aging
C/O Ms. Keller H. Bumgardner
P.O. Box 142
Columbia, S.C. 29202

Re: Problems of South Carolina's older citizens

Dear Committee Members:

Due to other engagements, I am not requesting to attend the public hearing September 12, 1980, but would greatly appreciate your taking the items listed below into your study as most serious matters.

1. Councils on Aging now providing transportation and escort to the elderly need more vehicles to enable them to continue to provide on a demand response, as well as regular routes. The elderly persons are not able to meet the demands of a mass transportation system. They are more in need of individual assistance.

2. The State could take a good look on how gasoline can be provided to these Council on Aging programs more economically. The cost is outrageous, especially in rural areas where there are long distances between pick-ups.

3. The Medicaid program could be made more effective, so more doctors will accept Medicaid patients.

4. From funds allocated for the energy crisis and weatherization programs, there should be an allotted amount set aside for older people. This allotted amount could be much more effective if channeled through the S.C. Commission on Aging and the Aging network. The elderly person would have a better chance of receiving these services. As it stands, now the Council on Aging must make referrals and follow-ups before the service is received. This takes extra paperwork and staff time.

5. In home services for the elderly, especially in rural areas, there is a great need such as chore and homemaker.

These items are of great concern to the older people, therefore I will be most grateful for your interest and support.

Thank you for your cooperation and the fine work you are doing.

Sincerely,

Brittie C. Bellamy

(Mrs.) Brittie C. Bellamy,
Executive Director

BCB/kla

cc: Mr. Harry Bryan,
Executive Director
S.C. Commission on Aging

Henry Smith
2317 Prince St.
Georgetown, SC 29440

2317 Prince, St.
Georgetown, S.C. 29440
September 9, 1980

Dear Sir and Madam:

My attention was drawn to an article in the local papers inviting ideas for legislation to benifit Older South Carolinians and will be received at a public hearing September 12th in Columbia.

Before retiring from my job at age 65 in 1977, I had a heating and air condition system installed in my home. The air condition is very helpful and necessary for my Wife's health because for several years she has suffered from a respiratory ailment.

It is our desire - in our old age - to live as comfrotably as possible on our fixed income but recently, the high and escalating cost of utility bills are taking an effect on our limited finiancial resources.

I submitted a resolution that was passed at the last precinct #3 Organizational meeting and it was adopted to be presented at the County Democratic Convention in Georgetown, S.C.

The resolution contain the following paragraph and my ideas for legislation:

Whereas We Commend our State Delegation to the General Assembly for their support of legislation that has helped the elderly and those that are on fixed income, it is hoped that they will continue to pursue an Economic

policy for this groups (the elderly) in regards to rising Inflation.

Inflation rates are highest for the necessities - food, housing, fuel Medical Care which demand the bulk of the elderly resources.

Be it resolve that the State and local government Continue to support Consumer issures such as escalating Utility rates.

Yours Very truly,

Henry Smith.

Senator Isadore E. Lourie, Chairman
Public Transportation Study Committee
Suite 601, Gressette Building
Columbia, SC 29202

SENATOR ISADORE E. LOURIE, CHAIRMAN
PUBLIC TRANSPORTATION STUDY COMMITTEE
STATEMENT FOR STUDY COMMITTEE ON AGING
PUBLIC HEARING SEPTEMBER 12, 1980

I certainly appreciate this opportunity to share some of my concerns about our seniors citizens and their transportation needs. For years, I have been actively involved in studying the many difficult problems associated with aging and have supported legislation to improve the lifestyles of our senior citizens. It has long been recognized that in order for the elderly to take advantage of the opportunities available to them, adequate and easily accessible transportation would be required.

Transportation continues to be the number one concern of our older South Carolinians. Many older persons do not have the transportation required to get groceries, see a doctor, visit a center, or take advantage of a great many services provided by the government. In addition, these people are often isolated from friends and family.

The most serious problems occur in the rural areas of the State where there is no public transportation available. Certain agencies or volunteer groups may provide transportation services to these rural residents, however, these budgets are limited and the transportation remains inadequate.

In the urban areas where public buses are operated, many older persons fear assault and/or robbery, are physically uncomfortable on the buses or are unable to walk to the bus stops which may not have the necessary benches or shelters. Many senior citizens would prefer to travel by taxi, but cannot

afford that expense.

The Public Transportation Study Committee, which I chair, has recently been directing its attention to the Regional Transportation Authorities (RTA). In the past, there has been a great deal of fragmentation and duplication of the transportation services provided in the rural areas of the State. The RTA s have coordinated and improved the existing transportation in these regions. There are, however, problems with the RTA law which our committee will attempt to resolve with an amendment we plan to introduce in January 1981.

While we must focus on coordinating transportation in these rural regions, we must now broaden our goals to include a statewide plan for public transportation. The study committee strongly recommends legislation which would create a Public Transportation Division within the South Carolina Department of Highways and Public Transportation. This new Division would serve as the State's central coordinating entity which would emphasize and unite South Carolina's public transportation.

Adequate public transportation will require a continuing source of funding. We must accept the fact that this funding must be derived from commitments from the federal, state and local governments.

As chairman of the Public Transportation Study Committee, I am in a position to help alleviate our State's transportation

problems, but your input and support are crucial. Advise your elected officials of your specific needs for public transportation and your willingness to support it. Follow legislation dealing with public transportation and express your support or reservations about these proposals to your lawmakers. Put your wisdom, talent and energy to work on improving public transportation. Your resources would be invaluable to our committee's efforts. We have made significant improvements in transportation and I am confident that together we can achieve our common goal of an efficient, cost effective, statewide public transportation system.

Elizabeth J. Kalish, Director
Sumter County Council on Aging
34 East Calhoun St.
Sumter, SC 29150

HEALTH CARE

I would like to speak to the health and medical needs of our elderly. Present solutions to the complex medical problems of the elderly can only be compared to nailing jelly to the wall.

As our seniors live longer they ;are more vulnerable to disease.....45% have one or more chronic conditions (heart, arthritis, hypertension, hearing loss and visual impairment).

Those with medicare cannot afford the deductible and the 40% of allowable costs. (Hospital stay of $6000...cost $1200).

The largest group we serve receive less than $320 per month. However, physician fees are the same for them as the young.....cannot afford.

We need legislative initiative to maintain quality, affordable health care.

There is a lack of geriatric physicians.

Few doctors accept medicaid, none make house calls, the hospital emergency room takes hours which is very wearing on the sick elderly, especially heart patients. THERE IS A DEFINITE NEED FOR GERIATRIC CLINICS.

There is also a need for a break on drug costs. The social security increase in July put many recipients over the medicaid cutoff by just a few dollars. Should be differential in SSI to very ill with no families.

Medicare and Medicaid should encompass the needs of the frail elderly whether delivered at home or in health facility

Great need for FAMILY DOCTORS. Major medical insurance is out of reach.

Reform of tort liability laws might be part of the solution to so many extra tests and procedures not medically necessary, but done for fear of malpractice.

A classic example - Elderly lady needed plastic knee in order to walk, local physician sent her to Duke where she was charged $75 for 5 minutes consultation and was told it would cost $6000 and required ½ down prior to operation